PARENT/GUARDIAN PERMISSION FOR ADMINISTRATION OF EPINEPHRINE (EPI-PEN) BY PEGASUS STAFF

Student's Name:_____ DOB:_____

If Parent/Guardian is unavailable in emergency, contact:
Name:_____

Address:_____ Grade:_____

Home Phone:_____ Other Phone(s):_____

Phone(s):_____

Relationship to student:_____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen):_____

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CONSENT FOR TREATMENT

I give permission to allow the administration of epinephrine by auto-injection (Epi-pen) by the Pegasus nurse or, in the absence of the Pegasus nurse, by an unlicensed member of the Pegasus staff who has been trained and delegated by the Pegasus nurse to my son/daughter, in the event of an emergency. I also allow the Pegasus nurse to share with appropriate Pegasus personnel information relative to this medication administration plan.

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Signature of Parent/Guardian Date