



Wissahickon School District

True Blue with a Heart of Gold

Epi-Pen: Permission to Carry Authorization

Parent/guardian request for permission to carry an epi-pen and acknowledgement that District Policy 210.1 applies to this signed permission.

Student Name and Grade: _____

Medication Dose: _____

Reason for Medication: _____

This student has received instruction in my office regarding the safe handling of the above medication and may do so in school and at school-related activities.

(Physician Signature)

(Telephone Number)

(Date)

(Parent/Guardian Signature)

(Telephone Number)

(Date)

The student will be evaluated by the Nurse. If an epi-pen is given, the parent/guardian and 911 will be called
District Policy 210.1 is available on the District website at www.wsdweb.org