ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR STUDENT TO CARRY AN EPIPEN ON PERSON

Name of Student | Birth Date | ID Number

Address | Zip Code | Telephone Number

The above named student is diagnosed with:

Description of condition or syndrome

I am requesting that the above named student be allowed to carry their Epipen and self-administer it if an allergic reaction occurs. I certify that the student has been instructed in self-administration and the usage of the following medication:

Name of Medication/Dosage

The student understands the need for the medication and the necessity to report to designated school personnel any signs/symptoms of an allergic reaction or anaphylactic shock. He/she is capable of using the medication independently.

Physician's Name_____ **Hospital Affiliation**_____
(print)

Address_____ **Telephone#**_____ **Fax#**_____

Physician's Signature_____ **Date**_____

***This request is valid for one year from the date of signature. Any medication or dosage change requires a new request form.**