CHICAGO PUBLIC SCHOOLS

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

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
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 school personnel any signs/symptoms of an allergic reaction or anaphylactic shock. He/she is capable of using the medication independently.

I can be reached at:

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.__