Self-Carry and Self-Administration Authorization

Emergency Epinephrine

Student Full Name: _____

Parent/Legal Guardian Authorization

I request that my child be permitted to carry and self-administer the prescribed emergency epinephrine medication while at school, during school-sponsored activities, and while being transported to or from school, as permitted by Texas law and Great Hearts Texas policy. I understand and acknowledge that:

- My child has been prescribed emergency epinephrine medication by a licensed healthcare provider.
- My child has demonstrated the knowledge and skills necessary to safely self-carry and self-administer the medication.
- I will provide the school with a current, unexpired emergency epinephrine medication.
- I will notify the school immediately of any changes to my child's medication or treatment plan.
- I understand that Great Hearts Texas may revoke this authorization if it is determined that my child is unable to safely self-carry or self-administer the medication.

Parent/Legal Guardian Signature

Signature: _____

Printed Name: _____

Date: _____

Licensed Healthcare Provider Authorization

I certify that this student has a medical condition requiring immediate access to emergency epinephrine medication and has demonstrated the knowledge and skills necessary to safely self-carry and self-administer this medication. This authorization is valid for the current school year unless otherwise specified. The student may carry and self-administer the prescribed emergency epinephrine medication while at school and during school-sponsored activities.

Medication: _____Dose/Strength_____

Special Instructions (if any):_____

Healthcare Provider Signature: _____

Printed Name: _____

Date: _____