

**Ferry Beach Ecology School**  
*Parent Consent for Management of Epi-Pen*

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_

I, \_\_\_\_\_, the parent or guardian of the above named student, request Ferry Beach Ecology School (FBES) use this Allergic Reaction Plan to guide healthcare management for my child while in attendance at FBES. My signature at the bottom of this page indicates:

I agree to:

1. Provide the necessary supplies and equipment for my child's care.
2. Notify the FBES school nurse of any changes in the student's health status before arrival.
3. Authorize the school nurse to communicate with my child's primary care provider as needed.
4. To provide a separate Epi-Pen to be kept in nurse's office if my child has permission to self-carry.

I have read and understand Ferry Beach Ecology Schools "Medical Management Plan for Student with Chronic Illness or Severe Allergy" and agree to work with my child's school and FBES to ensure the best care for my child.

I agree that medications that have been prescribed for my child's use may be administered by a school nurse or authorized staff member if:

1. the medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider and is not expired
2. I as the parent or legal guardian have granted permission below for the specific medications to be administered at FBES.

Allergies: List known allergies to medications, foods, or air-borne substances:

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Student's last allergic reaction date and symptoms:

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Student allergy occurs with:

Contact/Inhalation: Y/N

Ingestion: Y/N

Medications I have provided:

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Signature of parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Place of employment \_\_\_\_\_ Work phone \_\_\_\_\_

**To be filled out by student's health care provider: \***

- I certify that this child has a medical history of allergic reaction and has been trained in the use of the listed medication, and is judged by me to be:

\_\_\_ capable of carrying and self-administering the listed medication (s)

\_\_\_ NOT capable of carrying and self-administering the listed medication (s)

Healthcare Provider name \_\_\_\_\_ Phone \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

*\* Many schools require a similar form, signed by a health care provider, to be on file with the school nurse. If you can provide FBES with a copy of this form, this is generally an acceptable substitute for the health care provider signature above.*