



---

**PERMISSION FOR STUDENT TO SELF-ADMINISTER MEDICATION BY  
AUTO INJECTOR**

I hereby certify the following:

1. I \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_ (“Student”), a student in the Parkway School District (“District”), and am legally authorized to make educational and health care decisions for the Student.
2. I hereby give my permission for the Student to retain in his/her possession an Epi-pen auto injector, and to self-administer medication from such injector. This permission shall be effective during the school day; on school property, including but not limited to a school bus; and at all school activities, whether on or off school property or occurring during the regular school day.
3. I have provided the District with a written medical history of the Student’s experience with severe allergy or other potentially life-threatening anaphylaxis (“Condition”) and a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having the Condition.
4. I have provided the District with written certification from the Student’s physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self-administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.
5. I understand that the District and its employees or agents may disclose information provided in accordance with the foregoing paragraphs to administrators, school nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer medication by means of an auto injector, and shall incur no liability for the disclosure of such information.
6. I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student.
7. I understand that this permission form is effective for the school year for which it is granted, and that a new Permission Form and supporting documentation as described above, must be submitted for each school year.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

---

12657 Fee Fee Rd.

Saint Louis, MO 63146

(314) 415-5066 • FAX: 415-5046