CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES

PERMISSION TO CARRY EPI-PEN or AUVI-Q ON CAMPUS

Date: _____ School Year**:** _____/_____ Grade: _____

_____ has been instructed in the proper use of
(Student's name)

/

_____
(Name and Dose of Epinephrine) (Expiration Date)

_____
(Parent/Legal Guardian signature)

_____
(Parent Name Printed) (Phone)

Please have a prescription label put on the actual EPI-PEN or AUVI-Q. You can ask the pharmacist to print an extra prescription label for the school EPI-PEN or AUVI-Q.

1-23-18