Authorization to Carry/Self-Administration Inhaler/EPIPEN at ESASD

(Student to carry copy of this document with the medication at all times. Original on file in nurses' office)

Student ______________________________ DOB ____________________ Grade _____

Medication and dose ____

Time or indications for administration ____

Diagnosis ____

Side effects/conditions to observe ____

Duration (limit of one school year) ____

IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION

(It is preferable that another prescription labeled inhaler be kept in the nurse's office in case the first is left at home or lost)

Physician signature _______________________________________ Date _____________

Printed physician name ____________________________________ Phone ____________

Address ____

I have been instructed in the proper use of my prescription inhaler and fully understand how and when to administer this medication I will use this medication only as per the above instructions. I will not share this medication under any circumstances. I understand that should another student use my medication, the privilege of carrying the medication will be revoked. I will immediately report a lost/missing medication. I also agree to come directly to the school nurse/responsible adult after using medication.

Student signature ____ Date _________

I request that my child named above be permitted to carry/self-administer the above ordered medication. I understand that the medication must be in a properly labeled pharmacy container. I understand that the parent/guardian accepts the legal responsibility should the above medication be lost, given to or taken by a person other than the above named student. I understand that the ESASD has no legal responsibility when the above named student administers their own medication.

Parent/Guardian signature ____ Date _________

We accept the physician order, student's statement, and parent request. We will permit above name student to carry/self-administer prescribed medication. We reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk.

Principal ____ Date _________

School Nurse ____ Date _________