Authorization to Self-Carry an Epinephrine Autoinjector or Inhaler at School

School year: _____
School: _____
Fax: _____

1. Submit this completed form to the school office.
2. The epinephrine autoinjector or inhaler must have a prescription label attached and be unexpired.
3. ***A new authorization form must be received each school year and is subject to approval.***

PARENT/GUARDIAN to complete this section:

Student _____ DOB _____ Grade _____

Medication requested (one medication per form): ❑ Epinephrine autoinjector ❑ Inhaler

- I request my child be allowed to self-carry and self-administer the medication indicated for the current school year
- I will ensure the medication has a prescription label on it and replace the medication before it expires
- I confirm that my child understands the proper administration of the medication indicated, is responsible enough to safeguard it appropriately, and can use it correctly without supervision
- I acknowledge that CKSD and its employees and agents will incur no liability as a result of any injury arising from my child's self-administration of medications and agree to indemnify and hold harmless the district or school along with any of its employees or agents against any claims arising out of the self-administration

Parent/guardian printed name _____ Phone _____

Signature _____ Date _____

LICENSED HEALTHCARE PROVIDER (LHP) to complete this section: (avoid medical abbreviations)

Name of student _____

Condition being treated _____

Medication (one medication per form) _____

Dose _____

Route _____

Time/frequency to be given _____

Possible side effects _____

Inclusive dates: ❑ Current school year (default if neither box checked)

❑ Less than current school year _____ _____
Start Date End Date

As the LHP, I verify that this student has been taught the proper administration of the above medication, is responsible enough to safeguard it appropriately, and can use it correctly without supervision.

LHP printed name _____ Phone _____

Address _____ Fax _____

Signature _____ Date _____
MD, DO, ND, DMD, DPM, PA, ARNP, CNM