AUTHORIZATION FOR SELF-CARRY & ADMINISTRATION OF ASTHMA INHALER or EPI-PEN

Student's Last Name _____ First Name _____ Middle Initial _____ Date of Birth: month/day/year _____

Student ID# _____ Julian Union High School Name of School _____ Grade _____

In order for your child to carry inhaler or epi-pen on his/her person, the following must be understood and agreed upon by the student, parents and physician:

The student may utilize the prescribed inhaler or epi-pen as needed and directed by his/her physician. It is understood that the student has been trained and has demonstrated knowledge of proper use of the prescribed inhaler or epi-pen. The inhaler or epi-pen must be properly labeled with the student's name. BOTH THIS AUTHORIZATION FOR SELF-CARRY & ADMISTRATION FORM AND THE AUTHORIZATION FOR MEDICAL ADMINISTRATION PROTOCOL must be signed by physician and parents and placed on file at the school prior to your child carrying an inhaler on his/her person.

No direct monitoring will be conducted by the school staff. The student is responsible for self-administration of the inhaler or epi-pen and/or may submit a log of its use to the appropriate school staff. (The school staff is only responsible for recording on the medication log after the student states use.) If the student continues having difficulty breathing after reporting use of the inhaler or epi-pen, the parents will be notified by the appropriate school staff.

It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.

The district is not responsible for any risk involved with improper handling off this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with, or careless storage of the inhaler or epi-pen.

Reevaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of himself/herself or other students on campus.

_____ _____

Parent Signature Authorized Health Care Provider's Name (printed)

_____ _____

Student Signature Authorized Health Care Provider's Signature

MD/DO/DDS/PA/NP CA License# _____

Supervising Physician's Name/address/Phone#

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This form must be renewed at the beginning of each school year.