AUTHORIZATION TO CARRY AND SELF ADMINISTER
ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

Student Name: _____ Grade: _____ Parent Name: _____

Name of Medication _____

In order for your child to carry and administer his/her own Inhaler/Epinephrine Auto injector/or Pancreatic Enzyme Supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out **IN ADDITION** to the parent and licensed prescriber's normal authorization form for administration of medication in school.

A. To be completed by your child's licensed healthcare provider:

_____has been instructed in the proper use of the above-referenced medication(s). In my professional opinion, this student is responsible and able to utilize the medication(s) as directed by me without additional assistance or direction. This student should be allowed to carry and use the above medication(s).

_____

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child, _____be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in, and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. I understand that Gibson County Special School District (GCSSD) staff will be made aware that my child is self-carrying medications for self-administration. My child will immediately notify an employee of his/her school if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the Gibson County School District if and when he/she has any questions, concerns or adverse side effects, or must use their medication for an emergency situation. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that GCSSD and its employees assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's Inhaler/Epinephrine Self Injector/or PES. I furthermore agree to indemnify and otherwise hold harmless GCSSD, its employees and volunteers for any and all liability with respect to the student's use of such medication. A back-up dose of medication should be kept in the school nurses office.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

School Nurse reviewed responsibilities with student and documented on IHP on _____ (date.)
Nurse Signature: _____