AUTHORIZATION FOR ASTHMA INHALER OR EPINEPHRINE AUTO-INJECTOR TO BE CARRIED BY STUDENT AND SELF-ADMINISTER PRESCRIBED MEDICATION DURING SCHOOL HOURS

To: ____:
Name of building administrator/principal

Name: ___________________________________ Grade: ______ must receive the following prescribed short acting, metered dosed asthma inhaler to treat an acute asthma attack, or the following prescribed epinephrine auto-injector to treat anaphylaxis.

Name of medication:_________________________ Prescribed dosage: _________________________________

Time Schedule:____

Diagnosis or reason medication is needed:____

Length of time prescribed medication is required: _______ days _______ months ______ indefinitely _______

Potential side effects of medication: ____

Emergency response in the event the medication is not effective: ______________________________

____

____

____

Student demonstrates ability to properly self administer medication (circle) YES NO

Student has permission to carry medication during school hours (circle) YES NO

____
Signature of Physician (no stamped signature) Date

I do hereby release, discharge and hold harmless the McGuffey School District, its agents and employees, from any and all liability and claim whatsoever for the student self administrating the above medication should the child develop a reaction from the medication. I also understand that any violation of school policy no. 210.1 (Possession/Use of Asthma Inhalers/Epinephrine Auto-Injectors) will result in immediate confiscation of and the loss of the privilege for the child to carry/possess the medication during school hours.

____ ____________________
Signature of Parent/Guardian Date

Parent/Guardian:

In accordance to school policy 210.1 (Possession/Use of Asthma Inhalers/Epinephrine Auto-Injectors), to self administer the medication the child must be able to: (Please initial each line if reviewed)

1. Respond to and visually recognize his/her name. __________
2. Identify his/her medication. __________
3. Demonstrate the proper technique for self administering the medication. __________
4. Inform the nurse immediately following each use of the medication. __________
5. Demonstrate a cooperative attitude in all aspects of self-administration of the medication. __________

I have read and understand that my child must meet the above the criteria in order to have the privilege to carry his/her own asthma inhaler, or epinephrine auto-injector.

______________________________ __________________

Signature of Parent/Guardian Date

Child/Student Name: ______________________________

In accordance to school policy 210.1 (Possession/Use of Asthma Inhalers/Epinephrine Auto-Injectors), to self administer the medication the child must be able to: (Please initial each line if reviewed and understand)

1. Respond to and visually recognize his/her name. __________
2. Identify his/her medication. __________
3. Demonstrate the proper technique for self administering the medication. __________
4. Inform the nurse immediately following each use of the medication. __________
5. Demonstrate a cooperative attitude in all aspects of self-administration of the medication. __________
6. I understand that my privilege to carry/possess my medication will be removed if the school's policy is violated or if any other student is found to have possession of my medication or if any other student's safety is placed at jeopardy due to my possession of my medication.

The above information has been reviewed with me and I understand that I must meet the above criteria in order to have the privilege to carry my own asthma inhaler or epinephrine auto-injector.

______________________________ ______________________________

Student's Signature Date Nurse's Signature Date