

**AUTHORIZATION TO CARRY AND SELF ADMINISTER
RESPIRATORY MEDICATION OR EPINEPHRINE AUTO-INJECTOR**

This form must be completed so that we may provide the best care for your child. Please return this form to the school health office so that your child may have permission to carry and self-administer their:

- Respiratory medication
- Epinephrine auto-injector

If any changes occur during the year, please notify the school health office.

Name of Student Grade / Teacher

Name of Medication Dose Frequency of Use

Responsibilities for carrying respiratory medications or epinephrine auto-injector:

Observed

Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current <i>Authorization for Medication Administration</i> form on file in the Health office
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication labeled with student's name and directions for use.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student demonstrates correct use of prescribed medication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student describes the proper timing for prescribed medication use.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student agrees to not share their prescribed medication with another person.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student agrees to keep prescribed medication with student's belongings.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student agrees to come directly to health room if difficulty with breathing, wheezing or chest tightness continues after using prescribed medication.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Student and family agree to have someone notify school nurse that epinephrine auto-injector was used

The above mentioned student demonstrates an understanding and agrees to comply with the above specified responsibilities.

Student Signature R.N. Signature and Date

Comments: _____

My child will be responsible for carrying this medication and will self-administer. My child agrees to follow the district procedures concerning the handling and administration of this medication.

Parent / Guardian Signature and Date