REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL
(ONLY for Epi-Pen or Metered Dose Inhaler)

Student Name_____ Birth Date _____

School: _____ Teacher: _____Grade: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

MEDICATION 1	**MEDICATION 2**
Medication name: _____ Reason for Medication:_____ Dose: _____ Method of Administration:_____ Time of Administration:_____ Start: ☐ Immediate ☐ Other Date:_____ Stop: ☐ End of Year ☐ Other Date/Duration _____ ☐ For Episodic/emergency events only Restriction and/or important side effects: ☐ None anticipated ☐ Yes. Please describe:_____ _____ Special Storage Requirements ☐ Refrigerate ☐ None	Medication name: _____ Reason for Medication:_____ Dose: _____ Method of Administration:_____ Time of Administration:_____ Start: ☐ Immediate ☐ Other Date:_____ Stop: ☐ End of Year ☐ Other Date/Duration _____ ☐ For Episodic/emergency events only Restriction and/or important side effects: ☐ None anticipated ☐ Yes. Please describe:_____ _____ Special Storage Requirements ☐ Refrigerate ☐ None
<u>This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication</u> ☐ Yes -Supervised ☐ Yes -Unsupervised ☐ No This student may carry medication: ☐ Yes ☐ No Please indicate any additional information: _____	<u>This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication</u> ☐ Yes -Supervised ☐ Yes -Unsupervised ☐ No This student may carry medication: ☐ Yes ☐ No Please indicate any additional information: _____

Health Care Provider's Signature: _____ Date_____

Address: _____ Phone #_____

Sylvan Union School District

CONSENT FOR SELF-ADMINISTRATION OF MEDICATION
RELEASE OF MEDICAL INFORMATION AND RELEASE OF LIABILITY

I hereby consent for my child, _____ to self-administer the following medication during the regular school day or when attending school related activities:

☐ Auto-injectable epinephrine ☐ Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by the Sylvan Union School District.

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, its officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

_____ _____

Date *Signature of Parent/Guardian*

_____ _____

Date Reviewed by School Nurse *Signature of School Nurse*

☐ Asthma Contract attached

This request **MUST** be updated annually and medication claimed within one week beyond the end of the school year.