Authorization for Student Self-Administration of Inhalers/EPIPENs

ISD 282 St. Anthony/New Brighton Schools

Student Name: _____ Grade: _____
Allergies: _____

TO BE COMPLETED BY PRESCRIBING HEALTHCARE PROFESSIONAL:

I believe this student is capable of self-carrying and self-administering the medication(s) listed below:

Medication: _____ Dose: _____
Directions for use:_____
Medication: _____ Dose: _____
Directions for use: _____
I recommend self-administration of this medication for the treatment of:
_____
Comments: _____
Discontinue date: _____ (orders expire at the end of the school year unless discontinued earlier)

Signature of Licensed Provider _____ Date:_____
Printed Name: _____ Phone: _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

I give my permission for my child to self-carry and self-administer the medication as prescribed by my child's healthcare provider. I authorize the school nurse and the healthcare provider to share information about my child's medication and condition being treated.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Printed Name: _____

TO BE COMPLETED BY STUDENT:

I agree to use my medication only as directed by my healthcare provider.
I agree to seek help from Health Office staff if my medication does not work as expected (inhaler) or if I experience an allergic reaction and need to use my anaphylaxis medication (EPIPEN).
I agree not to let anyone else use my medication.
I agree to keep a current supply of my medication and bring it with me on field trips.

Student Signature: _____ Date: _____

TO BE COMPLETED BY THE SCHOOL NURSE:

_____I have reviewed this information with the student and agree that this student is capable of self-carry and self-administration of this medication.
____ I believe this student needs more practice before being capable of self-administration and will contact parents to make a plan to accomplish this.

Signature of School Nurse: _____ Date: _____