

AUTHORIZATION FOR SELF-ADMINISTRATION OF EPI-PEN or INHALER 2022-2023

No medication may be brought to school until parent/guardian & LHP have completed this form

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL (LHP):

Name of Student _____ DOB _____

Reason for medication _____

Medication Name/Dosage _____
(one medication per form)

Possible side effects _____

Start date _____ End date _____
(No longer than current school year)

As the LHP for this student, I verify that he/she has been taught the proper administration of the above medication and can use it properly without supervision.

Licensed Health Professional - please print Phone number

Licensed Health Professional's signature Date

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN:

I grant permission for my child, _____, to possess and use the above medication: 1) while in school; 2) at school sponsored activities; and 3) before or after any school activities while on school property.

School student attending: _____

I acknowledge that North Kitsap School District and its employees and agents will incur no liability as a result of any injury arising from my child's self-administering his/her medication. I also agree to indemnify and hold harmless the district and its employees and agents against any claims arising from the self-administration and trained staff's administration if a student is unable to self-administer.

I understand the medication carried by my child must have a pharmacy label in my child's name. I also understand that if the medication is misused by my child, shared with other students, or improperly safeguarded from abuse by other individuals, the privilege of carrying the medication will be revoked.

Parent/Guardian Name - please print Date Home phone number

Parent/Guardian signature Cell phone number