



## Authorization for Student to Carry a Prescription Inhaler or EpiPen

*Print Student's Full Legal Name*

This student needs to carry the following prescription-labeled inhaler or EpiPen at school. The student has been instructed in the proper use of the medication and fully understands how to administer this medication. It is preferable that a second/backup inhaler or EpiPen be kept in the school clinic. **List the medication, dosage and any specific instructions below.**

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Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_

I have been instructed in the proper use of my prescription medication and fully understand how to administer this medication. I **will not** allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked and I may be subject to disciplinary action. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby request that the above-named student, over whom I have legal custody, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above-named medication be lost, given, or taken by a person other than the above-named student. I understand that if this should happen, the privilege of carrying the medication may be revoked and my child may be subject to disciplinary action. I release the Bulloch County Schools and its employees of any legal responsibility when the above-named student administers his/her own medication.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_