NORTHERN YORK COUNTY SCHOOL DISTRICT
SELF-ADMINISTRATION OF ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR/Diabetes Medication PERMISSION FORM

Name _____ Name of Medication _____ Date _____

School _____ Grade _____ DOB _____

Criterion for student self-administration of Asthma Inhaler , Epinephrine Auto-Injector and/or Diabetes Medication

The prescribed medication shall be maintained in a clearly labeled original container noting the child's name, the medication name, and the time and/or special circumstances for self-administration.

Student is able to:

-Verbalize symptoms/situation related to the need for medication use.
-Demonstrate the correct technique for self-administration of the medication.
-Follow the emergency action plan as prescribed by physician.
-Inform the school nurse immediately after self-administering asthma inhaler or epinephrine auto-injector.
-Store medication in a secure location where it is easily accessible.

I have received instruction from my prescriber on proper safety precautions for the handling and disposal of the asthma inhaler, epinephrine auto injector and or diabetes supplies. I will take responsibility for carrying and self-administration of my asthma inhaler, epinephrine auto-injector, and/or diabetes medications at school. I have read and understand the school policy regarding self-administration and possession of this medication. If I violate this school policy, I understand that it will result in loss of privilege to self-carry my medication as well as possible disciplinary action in accordance with Board policy. **I understand that in order for me to self-administer and carry my medication, I must meet with the school nurse for final approval of this process.**

STUDENT SIGNATURE _____ Date _____

I certify that my son/daughter is able and responsible to carry and self-administer their asthma inhaler, epinephrine auto-injector, and/or diabetes related supplies. I give permission for self-administration and possession of the ordered medication for my child to use during school hours, at any time while on school property, at any school-sponsored activity, and during the time spent traveling to and from school and school-sponsored activities. I understand and consent to the stipulations of the school policy regarding self-administration of medication. I understand my child may lose this privilege if the policy is violated. I also agree that the school entity bears no responsibility for ensuring that the medication is taken. I understand that emergency medical services will always be notified when epinephrine is administered, whether or not the student manifests any symptoms of anaphylaxis. I will inform the school nurse if there are changes in this medication.

I hereby release, indemnify, and hold harmless the Northern York County School District, its employees, and its agents against any claim(s) arising out of the administration or self-administration of medication pursuant to this permission form, or related to the benefits or consequences of the prescribed medication. **I understand this permission form must be completed by both a physician and the school nurse prior to my child self-administering or carrying his/her medication.**

PARENT/GUARDIAN SIGNATURE _____ Date _____

It is my professional opinion that this student may carry and self-administer his/her medication according to the orders prescribed on the attached emergency action plan.

PHYSICIAN SIGNATURE _____Date _____

The student, _____has demonstrated competency for self-administration and responsible behavior in use of the prescribed medication.

SCHOOL NURSE SIGNATURE _____ Date _____