FORM B

—SCHOOL CITY OF MISHAWAKA—

AUTHORIZATION TO POSSESS AND SELF-ADMINISTER INHALERS, EPI-PENS & INSULIN

This form must be filed with the Principal annually.

Student Name: _____ **Grade:** _____

To Be Completed By Physician/Practitioner:

My patient _____ has been instructed in the proper use of _____. This student's well being is in jeopardy unless this medication is carried on his/her person: therefore we request that he/she be permitted to carry _____. He/She understands the purpose, appropriate method and frequency of this medication.

Physician/Practitioner_____ (please print)

Address_____

Phone:_____

Physician/Practitioner signature:_____ Date:_____

Parent/Guardian Authorization:

I permit my child to carry the above listed medication as ordered by his/her physician/practitioner. I understand that sharing medication with other students will result in disciplinary action. I understand that neither the school or the school board is liable for civil damages as a result of the student's named above self-administration of medication for an acute or chronic disease or medical condition as provided under IC20-8.1-5.1-7.5

Parent/Guardian Signature: _____ Date:_____

To Be Completed By the Student:

I understand the purpose, appropriate method and frequency of the above listed medication. I understand that sharing this medication with other students is potentially dangerous and will result in disciplinary action.

Student signature:_____ Date:_____

Termination of Medication:

I hereby withdraw my consent for my child to receive the above medication while at school.

Parent/Guardian Signature:_____ Date:_____

This form is in compliance with School City of Mishawaka Policy 5330 10/12