WRITTEN AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION AND/OR EPI-PEN BY A STUDENT AT A SCHOOL

Student Name: _____ Date of Birth: _____ Grade: _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication or Epi-Pen by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her medication. ☐ **Inhaler** ☐ **Nebulizer** ☐ **Epi-Pen (**please choose the ones that are appropriate)

I understand that:

- The School district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication including injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty medication devices.
- The school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with medication.
- The school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of medication.

I take sole responsibility for:

- The monitoring of medication, medication use, and refilling of prescriptions in a timely manner. The school will not be responsible for the supervising, recording, and monitoring of self-administered medication.
- Ensuring the student always carries his/her medication on his/her person.
- Deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- Informing school staff in writing of any changes in the student's plan for asthma and/or allergy management.
- Informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information.
- Informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- Coordinating distribution of the student's asthma/Epi-Pen management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

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I understand and agree to the conditions stated above. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the SCCPSS and its employees and agents of any legal responsibility related to the above-named student's possession and self administration of his or her medication/device.

Parent/Legal Guardian Signature_____ Date _____

I have been instructed in the proper use of my prescription and fully understand how and when to use the medication. I will always carry my medication with me and will not allow another student to use it under any circumstance. I understand and agree to the terms of the school policy.

Student's Signature_____ Date_____

The above-named student has been instructed and demonstrates understanding of the proper use of his/ her medication. It is my professional opinion that the student be permitted to carry and self-administer his/her medication. I have provided the parent/guardian with a written emergency management plan including the name, purpose, dosage, and administration directions of the medication.

Physician's Signature_____ Date_____

This form is to be returned to the School Nurse within 7 days from the day of receipt along with an asthma and/or food allergy action plan that I have been given.

Parent signature: _____ Date: _____

Received by: _____ Date: _____