HEALTH and WELLNESS SERVICES
1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

Emergency Self-Carry Medication Permit 2025-26

*Permit is required for student to carry and use medication in school or at school-related activities. Medication **must** be in the Original container with Label Instructions. This form must be completed by a physician.*

Student: _____ DOB: _____
School: _____ Grade: _____

Physical Condition (Diagnosis): _____

Treatment - check those that apply

❑ Inhaler (name) _____

❑ Epi Pen ❑ Twinject® ❑ diphenhydramine
❑ Other-explain

Specific treatment instructions:

_____

_____

I affirm the following:

	Yes	NO	
❑			Child received training in the proper use of the Epi-Pen, inhaler, and/or medication
❑			Child demonstrates the proper technique while using the Epi-Pen, inhaler, and/or medication.
❑			Recognizes and understands proper and prescribed timing for medication
❑			Will not share medication with others
❑			Agrees to come to clinic for evaluation after using inhaler/emergency medication
❑			I request that the child carry and self-administer the above-named medication during school hours and at school activities.

PRECAUTIONS/POSSIBLE UNTOWARD REACTIONS AND RECOMMENDED INTERVENTIONS
(USE OTHER SIDE TO EXPLAIN)

❑ In my opinion, this child shows capability to carry and self-administer the above medication
❑ The parent/legal guardian will supply additional emergency medication, indicated above, to be kept in the school clinic in case the child fails to have the self-carry medication.

The school nurses will accept the parent request and physician statement. They will permit and assist the student to be responsible but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. They will contact the parent as soon as possible in this event.

I acknowledge that my child has been instructed in the proper use of their medication and is capable of self-administration. I hereby release FWCS, its board, officers, employees, and agents from any liability related to my child's self-administration of medication. I understand that FWCS assumes no responsibility for ensuring the medication is taken or administered properly.

_____
Physician's Signature *Print Name* *Telephone* *Date*

_____
Parent/legal Guardian Signature *Student's Signature* *Telephone* *Date*

OVER (CONTINUE ON THE REVERSE SIDE)

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Things to watch out for, potential side effects, and recommended interventions:

Emergency Inhaler: _____

_____

_____

Epi-Pen: _____

_____

_____

Medication (specify)

_____

_____

_____

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