

School year _____

Brinnon School District

Phone: (360) 796-4646

Fax: (360) 505-4542

Authorization to Self-Carry an Epinephrine Autoinjector or Inhaler at School

1. The self-carry form is for epinephrine autoinjectors and/or inhalers only.
2. Submit this completed form to the school office prior to student self-carrying medication at school.
3. The epinephrine autoinjector and/or inhaler must have a prescription label attached and be unexpired.
4. **A new authorization form must be received each school year and is subject to approval.**

**** THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL ****

Name of Student: _____ Date of Birth: _____

Reason for Medication: _____

Name of Medication: (one per form) _____

Dosage & Mode of Administration: _____

Time/frequency to be given: _____

Inclusive dates during which medication is to be given: (current school year, if left blank) _____

Possible side effects of medication: _____

As a licensed health professional, I verify that this student has been taught the proper administration of this medication and can use it properly without supervision.

Printed Name of Licensed Health Professional Phone

Signature of Licensed Health Professional Date

**** THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN ****

- I request my child be allowed to self-carry and self-administer the medication indicated while at school, including before and after school activities and any school sponsored field trips.
- I will ensure the medication has a prescription label on it and replace the medication before it expires.
- I confirm that my child understands the proper administration of the medication indicated, is responsible enough to safeguard it appropriately, and can use it correctly without supervision.
- I understand that if the medication is intentionally misused by my child, shared with other students, or improperly safeguarded from abuse by other individuals, the privilege of carrying the medication may be revoked.
- I acknowledge that Brinnon School District and its employees and agents will incur no liability as a result of any injury arising from my child's self-administering his/her medication. I also agree to indemnify and hold harmless the district and its employees and agents against any claims arising from the self-administration and trained staff's administration if a student is unable to self-administer.

Printed Name of Parent/Guardian Phone

Signature of Parent/Guardian Date