

**SELF-ADMINISTRATION OF MEDICATION FOR SY: \_\_\_\_\_**

**A. Parent's Request and Authorization**

I, THE UNDERSIGNED, request and authorize my child \_\_\_\_\_ to self-administer his/her medication: **inhaler** **auto-injectable epinephrine (EpiPen)** while at school.

*(Circle one or both as appropriate)*

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times his/her medication as long as he/she does not endanger him/herself, or endanger other persons, and will not misuse the medication.
- I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, THE UNDERSIGNED,

- understand that the Department of Education, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child;
- shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child;
- understand that this authorization shall be effective for this current school year and must be renewed annually.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**B. Physician's Certification**

I, THE UNDERSIGNED, certify that \_\_\_\_\_ has asthma,  
(student's name)  
anaphylaxis or another related potentially life-threatening illness \_\_\_\_\_, and  
(specify)

he/she is capable of and has been instructed in the proper method of self-administration of

his/her own asthma and/or auto-injectable epinephrine (EpiPen) medication.  
(circle appropriate medication)

**Physician's Name:** \_\_\_\_\_ **Physician's Signature:** \_\_\_\_\_  
(type/print)

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed/Accepted by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Principal or DOE Designee

**Received by PHN/SHA:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DOE: July, 2004**

**Inhaler and EpiPen Consent Form**