THIS SIDE TO BE COMPLETED IF MEDICATIONS FROM HOME ARE TO BE GIVEN AT SCHOOL (Rx and OTC)

Centralia High School District 200
School Medication Authorization Form

Name of Student_____Date of Birth_____Grade_____
Name of
Parent_____

Address_____Phone #_____

Physician's Name_____Phone #_____
Physician's
Address_____

Name of Medication_____Dosage of Medication_____

Directions for Use_____

Reason for Medication (Indicate type of illness)_____

Other Medication(s) student is receiving at
home_____

_____

Possible Side Effects of Medication(s)_____

The approximate length of time that the student will receive this medication

is:_____

X_____Date_____
Parent Signature

X_____Date_____
Physician Signature

Note to Physician and Parent: If medication is an inhaler or an EpiPen®, and it is medically necessary for the student to carry the inhaler or EpiPen® with him/her at all times during school hours, please complete and sign the Self Administration of Emergency Medications form on the reverse side.

Please complete the reverse side if the student will need to carry an inhaler of EpiPen while at school.

This side must also be completed if the student will need to carry an inhaler or EpiPen while at school.

SELF-ADMINISTRATION OF EMERGENCY MEDICATIONS
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 Centralia High School District 200, 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 inhaler_____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:_____

Received by ALB, RN:_____ Date:_____

Inhaler and EpiPen Consent Form