**DeKalb County Eastern Community School District**

Eastside Jr./Sr. High School
603 East Green Street
Butler, IN 46721
(260)868-2186

**AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION**
**TO BE COMPLETED AND SIGNED BY A PHYSICIAN YEARLY**

School Year: _____

Student Name: _____ D.O.B.: _____

School: _____Grade: _____

Physical condition(s) for which treatment is to be given: _____

Treatment required: _____

Inhaler name: _____ EpiPen®_____ EpiPen Jr®_____ TwinJect® _____

**Directions for use of above**: _____

**Self-Administration of: ___ Medication ____ Inhaler ____ EpiPen® ____ TwinJect®**

**Check the following:**

____ Yes Student received training in the proper use of the emergency medication
____ Yes Student demonstrates the proper technique while using emergency medication
____ Yes The child recognizes proper and prescribed timing for medication
____ Yes The child does not share medication with others
____ Yes The child agrees to come to the clinic after using inhaler/emergency medications for evaluation
____ Yes I request that the child carry and self-administer the above named medication during school hours and at school activities

**Precautions/possible reactions and recommended interventions** (use reverse if needed)

_____

____ The parent/guardian will supply additional medication to be kept in the school clinic in case the child fails to have the medication with him/her.
____ In my opinion, this student shows capability to carry and self-administer the above medication.

*The school nurse will accept the parent request and physician statement. He/She will permit and assist the student to be responsible, but reserve the right to withdraw privilege if the student shows signs of irresponsible behavior, or if there is a safety risk. The school nurse will contact the parent as soon as possible in this event. The Dekalb County Eastern CSD and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student outside of the supervision of the RN.*

Medical Provider Signature: _____Phone: _____

Medical Provider Name: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

Student Signature _____Date: _____