

SELF POSSESSION OF INHALER/EPI-PEN BY A STUDENT

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____

Authorization to self-possess medication is required from a health care provider. The student's parent/guardian must provide the school with completed physician orders:

- **Permission For Medication** (For possession of an inhaler)
- **Health Care Provider: Emergency Administration of Epinephrine** (For possession of an Epi-pen).

Medication _____

The medication will be located:

Student's locker _____ Student's backpack/purse _____ Other _____

I understand that the Hawkins County School System shall not be held responsible or liable for the administration of the above listed medication. The parent/guardian releases the school district and its employees and agents from liability for any injury that may result from the student's self possession and self-administration of medication. It is the responsibility of the parent/guardian to make sure the child carries the medication on a daily basis as well as on field trips and other off campus activities. It is further understood that my child has received the appropriate training and agrees to follow the guidelines for administration and carrying on person the medication. The school may suspend or revoke the student's possession and self-administration privileges if the student misuses or makes the medication available for usage by another person. If a student uses the medication in a manner other than prescribed, the student may be subject to disciplinary action per board policy.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____ Cell Phone _____

RETURN TO: _____
SCHOOL FAX # _____ SCHOOL NURSE _____

PERMISSION FOR MEDICATION
(PRESCRIPTION AND NON-PRESCRIPTION)

A responsible adult must bring the medication to the school. Student possession of any form of medication that has not been checked into the principal's office is subject to disciplinary action. Medications should be taken at school only when the student's health requires that they be given during school hours. No medication will be sent home by students.

All medication must be brought to school in the original, unopened container and must be labeled with the student's name.

Students Name _____	DOB _____	Grade _____
School _____	Teacher _____	
Reason for Medication _____	Allergies _____	
Medication _____	Dosage _____	Time(s) _____
Route (circle): Oral Topical Inhaled Other _____	Start Date _____	Stop Date _____
Possible Side Effects _____		
I give permission for school personnel to assist my child in self-administering the above medication. I acknowledge that I have instructed my child in the correct administration of this medication and that my child is competent to self-administer the medication with assistance. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed below. * In the event of a school schedule change or delay: It is the parent's responsibility to notify the school nurse of any changes to your child's medication schedule.		
Parent/Guardian Signature _____	Date _____	Home Phone _____
Work Phone _____	Mother's Cell _____	Father's Cell _____
Emergency Contact _____	Phone _____	
Comments _____		
*If over-the-counter medication, stop here. *If prescription medication, complete entire form. (Prescription medication must be brought to school in the original, pharmacy labeled container.)		
Inhaler: Has the student been instructed in self-administration of inhaler? _____		
Assessment of student's competency for Self-Possession and Self-Administration of prescribed inhaler medication: _____		
Additional Health Care Provider instructions to the above: _____		
Print Health Care Provider's Name _____	Phone Number _____	Address _____
Health Care Provider's Signature _____	Date _____	