Form B (2 pages)

St. Joseph School

5411 South Main Street Sylvania, Ohio 43560

Authorization for Student to Carry Medication(Inhaler or Epi-Pen)
Must be read and completed by Parent/Guardian and Student

__________________________________ has been instructed in the proper use of
(name of student)

__________________________________. We request that he/she be permitted
(name of medication)

to carry the medication on his/her person or keep in his/her book bag, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of this medication. He/she also understands this medication is not to be shared or used by others. I also understand that my child will not be monitored when using this medication nor will a specific record of its use be kept unless he/she communicates this information to the clinic.

I authorize school personnel to allow use of this above medication to the above named child as ordered by our health care provider. I also authorize the school nurse to consult with the health care provider about my child's medication needs. I will see that my child's medication is properly labeled with the name of the medication and my child's name.

I understand that the student is responsible for the proper maintenance and use of the medication. I understand that if the student is found to have shared his/her medication at school, or otherwise abused the medication or device, the student will not be permitted to carry his/her medication at school and disciplinary action may also occur. I understand, and have informed the student , that he/she must immediately notify the school bus driver, school principal, school nurse, or teacher if his/her medication is lost or taken from him/her by another person.

In consideration of the administration of medical services as requested and authorized by this form, I/we, or myself/ourselves, and my/our heirs, executors, administrators and assigns, do hereby waive, release and forever discharge and agree to indemnity and defend the School and Diocese of Toledo, their members, officers, administrators, employees, servants and agents from and against all claims, demands, or causes of action by any person or entitles, for loss, cost, injury, or damage whatsoever arising from or claimed to arise from or in any way connected with the administration of authorized medical services to the student named above.

As Parents/Guardians of the child named above I/We acknowledge that I/WE have read and understand the above statements. As the student named above, I have read and understand the above information and the responsibility I assume in keeping the above named medication on my person.

PARENT/GUARDIAN__________________________________   ________________
(Signature)   (Date)

STUDENT ____   _______________
(Signature)   (Date)

INFORMATION TO BE PROVIDED BY PHYSICIAN WHEN STUDENT IS AUTHORIZED TO CARRY AN INHALER/EPI-PEN AT SCHOOL

STUDENT'S NAME: ___________________________________ DATE _______________

STUDENT'S ADDRESS: ____

NAME OF MEDICATION: ____

DOSAGE AND TIME TO BE TAKEN: ____

DATE TO BEGIN ADMINISTRATION: ____

DATE TO CEASE ADMINISTRATION: ____

SPECIFIC INSTRUCTIONS FOR USE: ____

ADVERSE REACTIONS, IF ANY, THAT MIGHT OCCUR TO THE STUDENT USING THE INHALER: ____

____

INSTRUCTIONS TO FOLLOW AFTER MEDICATION USE OR IF MEDICATION DOES NOT PRODUCE
EXPECTED RELIEF: ____

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____

POSSIBLE ADVERSE REACTIONS TO AN UNAUTHORIZED USER: _______________

____

The above named student knows and understands the proper use of his/her Medication and should be allowed to carry it on his/her person.

Physician Name: _____________________________ Physician's Emergency # __________

Physician's Signature _________________________________ Date ____________________

A new form must be completed whenever the prescription changes and at the beginning of each school year.