Jal Public Schools

SELF-ADMINISTRATION OF MEDICATION FOR SY: ________

A. Parent's Request and Authorization

I, THE UNDERSIGNED, request and authorize my child_______________________________________
to self-administer the following medication/s while at school with a written directive/order from my child's health care practitioner:

______ **1. Asthma treatment medication/s (inhaler)**

_______ **2. Anaphylaxis emergency treatment medication (auto-injectable epinephrine)**
(Check one or both as appropriate)

I give this authorization based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- My child must demonstrate her/his skill level necessary to use the medication and/or any device that is necessary to administer such medication as prescribed by the health care practitioner to the school nurse for final self-medication approval.
- My child will have an Individualized Health Care Plan (IHCP) developed by the school nurse, parent/guardian, and health care practitioner.
- 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.
- I understand that notwithstanding any provision of state law to the contrary, the school (including its employees and agents) is to incur no liability as a result of any injury arising from such self-administration of medication and I as the parent/guardian will indemnify and hold harmless the school (including its employees and agents) against any claim arising out of such self-administration of medication.

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 __________________________,
(specify)
and he/she is capable of and has been instructed in the proper method of self-administration of his/her own

______ **1. Asthma treatment medication/s (inhaler)**

_______ **2. Anaphylaxis emergency treatment medication (auto-injectable epinephrine)**
(Check one or both as appropriate)

Physician's
Name: ____________________________________ **Signature:** _____________________________
(type/print)
Address: ___________________________________ Telephone: ___________ Date _____________

Reviewed/Accepted by: _____________________________________ Date: __________________
(school nurse)

Inhaler and EpiPen Consent Form