Health Care Provider Authorization Administer Asthma Inhalers and/or Epinephrine Auto-Injectors

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

Child's Name: _____ D.O.B: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of this medication: _____

Side effect that need to be reported: _____

Is the student qualified and able to self-administer this medication: ___Yes ____No

Starting Date: _____ End Date: _____

Other medication used outside of school _____

_____ _____
(signature of health care provider) (license number)

_____ _____
(phone number) (date)

See Back

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Authorization to Administer Asthma Inhalers and/or Epinephrine Auto-Injectors

PLEASE FILL OUT ONE SHEET PER MEDICATION AND CHILD

The Parent/Guardian of: _____ (child's name)
Give permission for my child to carry and self-administer the following medication.

Medication: _____
_____

Medication Expiration Date: _____

At the following Time(s): _____

As a parent/guardian of the above-named child I relieve Howard Gardner Multiple Intelligence Charter School and all employees of any responsibility for the benefits or consequences of the prescribed medication. I also acknowledge that the Howard Gardner Mi Charter School will bear no responsibility in ensuring that the medication was taken. I understand that carrying an asthma inhaler or epinephrine auto-injector is a privilege to my child. The loss of this privilege will be enforced if the school policy pertaining to such self-administration is abused and/or ignored.

By signing this document, I give my permission for my child's health care provider to share information and the administration of this medication with the school nurse.

_____ _____
Parent/Legal Guardian's signature Date