AUTHORIZATION TO CARRY AND SELF ADMINISTER ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

Student Name (print)		Parent / Guardiar	Parent / Guardian Name (print)	
Student Number			Name of School	
Name of Medication				
supplement (PES), you repermitted to carry or ad	must fully complete an minister his/her own me out IN ADDITION to the	r his/her own inhaler/epi-pen/od return this form annually or dication. This is for the safety of parent and licensed prescriber	your child will not be f your child and others.	
A. To be completed	by the Florida licensed	healthcare provider:		
my professional opinion,	this student is responsible	roper use of the above-reference e and able to utilize the medico his student should be allowed to	ition(s) as directed by	
(Licensed Prescriber's Sig	nature)	(Phone Number)	(Date)	
B. To be completed	by the parent/legal gue	ardian		
transit to or from schounderstands the purpose child understands that medication. My child ache/she will not share it or is a violation of the Stud My child will immediately student uses his/her med of the District School Boadverse side effects. It is of carrying his/her med School Board of Pasco dosage, replacement if PES. I furthermore agree	cation(s) while in school or school-sponsored, appropriate method, he/she is responsible cknowledges and agreed otherwise allow it to be ent Code of Conduct way notify an employee of lication, equipment, or spord of Pasco County is understood that if ther lication will be rescinded County assumes no respondent of the lication will be rescinded to indemnify and other and volunteers for any and	be permitted to carry on participating in school-sport activities. My child has be dosage, frequency and use of he and accountable for carryings that the medication is for his/less the District School Board of Postupplies. My child will immediate if and when he/she has any one is irresponsible behavior or a seed. I understand and acknowly ponsibility whatsoever for the reministration of the above stude that all liability with respect to the result.	nsored activities, or in een instructed in and his/her medication. My ng and using his/her her use alone and that had that to do otherwise to disciplinary action. asco County if another ely notify an employee questions, concerns or afety risk, the privilege ledge that the District maintenance, storage, ent's inhaler/epi-pen/or School Board of Pasco	
Date Parent / Guardian Signature		ınature		
Date		Student Signatu	Student Signature	

AUTHORIZATION TO CARRY DIABETES EQUIPMENT AND SELF ADMINISTER DIABETES MEDICATION/PROCEDURES

Student Name (print)		Parent / Guardian Name (print)	
Student Number	Grade	Name of	School
Medication(s)/Procedure	(s)		
fully complete and return his/her own medication.	n this form annually or yo This is for the safety of y	her own diabetes equipment/medicat our child will not be permitted to carry our child and others. This form must be r's normal authorization form for adn	or administer e filled out IN
C. To be completed	by the Florida licensed he	ealthcare provider:	
/procedure(s). In my promedication(s) and/or car	fessional opinion, this stuc rry out these procedure(s	per use of the above-referenced medic lent is responsible and able to utilize the as directed by me without additional of e diabetes equipment/medication(s) lis	e assistance.
(Licensed Prescriber's Sign	nature)	(Phone Number)	(Date)
D. To be completed	by the parent/legal guar	dian	
activities, or in transit to a and understands the periodication. My child unhis/her medication/equipis for his/her use alone as student(s) and that to do the student to disciplinar Board of Pasco County i will immediately notify ar has any questions, conceptation or a safety risk, and acknowledge that whatsoever for the maint medication/equipment.	or from school or school-spurpose, appropriate in aderstands that he/she is oment. My child acknown that he/she will not shootherwise is a violation of y action. My child will imfanother student uses his employee of the District cerns or adverse side efficients or	be permitted to carry and self-archile in school, participating in school ponsored activities. My child has been nethod, dosage, frequency and us responsible and accountable for carryilledges and agrees that the medication are it or otherwise allow it to be used if the Student Code of Conduct which is school Board of Pasco County if and fects. It is understood that if there is a his/her medication will be rescinded. For administration of the above stude indemnify and otherwise hold harmle volunteers for any and all liability with regart to s. 1002.20(3)(j).	col-sponsored in instructed in instructed in instructed in ine of his/her ing and using an/equipment by any other might subject District School lies. My child when he/she irresponsible I understand responsibility ent's diabetes is the District
Date		Parent / Guardian Signature	
Date		Student Signature	