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

Student Name (print) | Parent / Guardian Name (print)

Student Number | Grade | Name of School

Name of Medication _____

In order for your child to carry and administer his/her own inhaler/epi-pen/or pancreatic enzyme supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out **IN ADDITION** to the parent and licensed prescriber's normal authorization form for administration of medication in school.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s). In my professional opinion, this student is responsible and able to utilize the medication(s) as directed by me without additional assistance or direction. This student should be allowed to carry and use the above medication(s).

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's inhaler/epi-pen/or PES. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use of such medication pursuant to s. 1002.20(3)(h),(i) and/or (k).

Date | Parent / Guardian Signature

Date | 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) _____

In order for your child to carry and administer his/her own diabetes equipment/medication, you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out **IN ADDITION** to the parent and licensed prescriber's normal authorization form for administration of medication in school.

C. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me without additional assistance. This student should be allowed to carry and use the diabetes equipment/medication(s) listed above.

(Licensed Prescriber's Signature) (Phone Number) (Date)

D. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s)/procedure(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication/equipment. My child acknowledges and agrees that the medication/equipment is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, or administration of the above student's diabetes medication/equipment. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use of such medication/equipment pursuant to s. 1002.20(3)(j).

Date | Parent / Guardian Signature

Date | Student Signature

Revised 12/10