LIMA CENTRAL CATHOLIC
HIGH SCHOOL

Permission to Carry and Self-Administer Asthma Inhaler

A new form must be completed whenever there are changes in medication, dose, frequency, etc. and also at the beginning of each school year.

Requires BOTH parent/guardian and physician's signatures

Student's Name: ______________________ Grade: ____________ Date: ____________

Address: ____

Daytime Phone: ______________________

Emergency Contact: ______________________ Phone: ____________

Emergency Contact: ______________________ Phone: ____________

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL: BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this form.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Lima Central Catholic personnel to communicate with my child's health care provider as necessary concerning the use of this medication.

☐ As the Parent/Guardian of the above named student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event or program sponsored by, or in which the student's school is a participant. I will instruct my child to inform school personnel if he/she has used the auto-injector so that the school employee can immediately call 911. I will provide a backup dose of the medication to the principal or school nurse as required by law.

☐ I hereby release, discharge, and indemnify the Diocese of Toledo, Lima Central Catholic, the Principal, the School Nurse, and any other persons involved, in the overseeing of medication herein described, from all claims, demands, actions, judgments, and executions which may arise from the overseeing or administration of the medication. The undersigned have read this form and understand all of its terms.

______________________ ____________ ____________
Parent/Legal Guardian Signature | Date | Daytime Phone

______________________ ____________ ____________
Parent/Legal Guardian Signature | Date | Daytime Phone

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The following information MUST be completed by the Healthcare Provider prescribing the epinephrine auto-injector (Epi-Pen).

I verify that this medication must be taken by ______________________________, during school hours.

Student's Name: ______________________ Grade: ____________ Date: ____________

Medication: ______________________ Dosage: ______________________

Route: ____________ Begin Date: ____________ End Date: ____________

Circumstances in which the auto-injector should be used: (include allergies causing anaphylaxis).

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Procedure to follow in the event that the student is unable to administer the anaphylaxis medication or the medication does not produce the expected relief from the student's anaphylaxis:

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Adverse reactions that should be reported to the healthcare provider:

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Adverse reactions for an unauthorized user:

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As the above named student's healthcare provider I have determined that the student is capable of possessing and using the auto-injector appropriately and I have provided the student with training in the proper use of the auto-injector. According to state law I have prescribed a back-up auto-injector to be kept at the school.

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______________________________________ ____________________
Healthcare Provider's Signature Date

______________________________________ ____________________
Healthcare Provider's Name Emergency Phone

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