Catholic Schools of Fairbanks

Request for Self-Administration of Medication for Asthma or Anaphylaxis Inhalers or Auto Injectable Epinephrine to be Completed Annually

If this form is properly completed and returned to the school nurse/principal, the Catholic Schools of Fairbanks may assist parents when their child's physician has prescribed medication for the child. The medication may only be self-administered if it is in the original bottle/container marked with the student's name, dosage, time of **administration, physician, pharmacy, and date of purchase.**

Student: _____ DOB: _____ Grade: _____

PHYSICIAN SECTION: (TO BE FILLED OUT BY THE PHYSICIAN)

Medication: _____Diagnosis: _____

Dosage and Time of Administration: _____

Discontinue Medication On: _____

For Inhalers, student may keep this on his/her person: YES: _____ NO: _____ N/A: _____

For Auto Injectable Epinephrine,

student may keep this on his/her person: YES: _____ NO: _____ N/A: _____

POSSIBLE SIDE EFFECTS:

- ☐ AGGRESSION
- ☐ EDGINESS
- ☐ HEADACHE
- ☐ JAW CLENCHING
- ☐ LOSS OF APPETITE
- ☐ SLEEP PROBLEMS
- ☐ STOMACH ACHE
- ☐ WEIGHT LOSS
- ☐ Other:_____

I certify that this student has received instruction in the proper and safe method of self-administration of the medication, that this medication is intended for the sole use of the student and that this student has demonstrated the skill level necessary to use the medication and any device that is necessary to administer the medication as prescribed.

Other Medications Student is Taking: _____

Physician's Signature: _____Physician's Phone: _____ Date: _____

Parent/Guardian Statement: As the parent/guardian of the above-named student, I do hereby request the school permit the above-named student to carry and self-administer medication approved by the student's health care provider. I agree not to institute suit against the school for administration or non-administration of the medication, to defend and hold the school harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school and its employees from any liability arising out of this agreement.

I will notify the school nurse/principal immediately if the medication is changed. I give my permission for the exchange/release of medical information regarding the above student/treatment. Furthermore, I acknowledge that if the student self-administers epinephrine, the student must notify school staff or nurse prior to administration and the 9-1-1 (Emergency Medical Services) must be called.

Parent/Guardian Printed Name:_____ Signature:_____ Date: _____

PERSCRIPTION INFORMATION:

Physician's Name: _____ Pharmacy: _____ RX Number: _____

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