MCCALL-DONNELLY SCHOOL DISTRICT NO. 421

120 IDAHO ST, MCCALL, IDAHO PHONE (208) 634-2161

AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/EMERGENCY ALLERGY MEDICATION (BENEDRYL/EPI PEN)

STUDENT'S NAME: ___________________________ GRADE: ________ DOB: ______________

PARENT/GUARDIAN NAME: ___________________ TELEPHONE: (HOME) __________________
(WORK) __________________

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

____ __________________

Parent/Guardian Signature Date

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT:

I am recommending that the above named student be allowed to self-administer the following medication:

Medical condition: ASTHMA____________________________ ANAPHYLAXIS__________________

Name of medication: ____

Medication dosage: ____

Possible side effects and/or special precautions to be taken: _____________________________________

____

Actions to take in case of emergency: ____

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This child may carry and self administer the above medication, and is trained and proficient in self-administration.

Trainer's Name: ________________________________ Date of training: ______________

This authorization is in effect for one year from date of signature.

____ ____________

Physician's Signature *(or enclose copy of prescription from box)* Date

Type or print physician's name:

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