



Kimberly School District

141 Center Street West Kimberly, Idaho 83341 Phone: 208-423-4170 Fax: 208-423-6155

**AUTHORIZATION TO CARRY AND SELF ADMINISTER
RESPIRATORY MEDICATION OR EPINEPHRINE AUTO-INJECTOR**

This form must be completed so that we may provide the best care for your child. Please return this form to the school health office if you desire that your child may have permission to carry and self-administer their:

- Respiratory medication
- Epinephrine auto-injector

If any changes occur during the year, please notify the school nurse and/or office.

Name of Student	Grade / Teacher
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Name of Medication	Dose	Frequency of Use
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Name of Medication	Dose	Frequency of Use
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Responsibilities for carrying respiratory medications or epinephrine auto-injector:

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| Yes | No | N/A | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication is correctly labeled with student's name and directions for use. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student demonstrates correct use of prescribed medication |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student describes the proper timing for prescribed medication use. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student agrees to not share their prescribed medication with another person. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student agrees to keep prescribed medication with student's belongings. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student agrees to come directly to office if difficulty with breathing, wheezing or chest tightness continues after using prescribed medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student and family agree to have someone notify school nurse that epinephrine auto-injector was used |

The above mentioned student demonstrates an understanding and agrees to comply with the above specified responsibilities.

Student Signature	R.N. Signature and Date
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Comments: _____

My child will be responsible for carrying this medication and will self-administer. My child agrees to follow the district procedures concerning the handling and administration of this medication.

Parent / Guardian Signature and Date