Central Kitsap School District

Authorization for Student to Self-Administer EPI-PEN or INHALER School Year: 2019-20

Do not send medication with your child until this form has been signed by parent and licensed healthcare provider and submitted to the main office. Permission must be renewed each school year and be kept on file at the school.
A current unexpired Authorization Form must be received each school year.

Parent/guardian to complete this section:

Name of student: _____ DOB: _____

Medication requested (only one medication per form): ❑ Epi-pen ❑ Inhaler

I grant permission for my child to possess and use his/her prescribed Epi-pen or inhaler while in school, at a school sponsored activity or in transit to or from school or school sponsored activities. I understand that the unexpired medication must have an accurate pharmacy label in my child's name. I also understand that if the medication is misused by my child, shared with other students, or improperly safeguarded from abuse by other individuals, the privilege of carrying the medication will be revoked. I acknowledge that CKSD and its employees and agents will incur no liability as a result of any injury arising from my child's self-administration of his/her medications. I also agree to indemnify and hold harmless the district or school along with any of its employees and agents against any claims arising out of the self administration.

Printed name: _____ Phone: _____

Signature: _____ Date: _____

Licensed healthcare practitioner to complete this section: (print or type without abbreviated medical terminology)

Name of student: _____

Condition being treated: _____

Medication (only one medication per form): _____

Dose: _____

Route: _____

Time to be given at school: _____

Inclusive dates for medication to be given:

☐ Current School Year

☐ Less than Current School Year _____ _____
(Start Date) (End Date)

As the LHP for this student, I verify that (s)he has been taught proper administration of the above medication, is responsible enough to store it properly and can use it correctly without supervision.

Printed name: _____ Phone: _____

Address: _____ Fax: _____

Signature: _____ Date: _____

❑ Student has demonstrated the necessary skill level to use this medication.

Signature of school nurse: _____ Date: _____

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