Authorization For Students to Carry a Prescription Inhaler, Epinephrine Auto Injector, Insulin, and Diabetic Supplies, or Other Approved Medication

_____needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or

_____prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: _____

Practice Name | Address | Telephone Number

Examiner's Name (Please Print) | Credentials

Examiner's Signature | Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the school nurse each time I take my medication.

_____ _____

Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry, and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above- named student administers his/her own medication.

Parent/Guardian Name (Please Print) | Parent/Guardian Signature | Date