

**DEKALB COUNTY SCHOOL DISTRICT**

**SCHOOL HEALTH SERVICES**

**Authorization for Student to Carry**

**Prescription Inhaler, Epi-Pen, or Insulin**

\_\_\_\_\_ needs to carry the following prescription labeled inhaler, Epi-Pen, or insulin 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 labeled inhaler, Epi-Pen, or additional insulin be kept in the clinic in case the first is lost or left at home.)

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Medication	Dosage and Directions
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Physician's Stamp	Physician's Signature	Date
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I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. 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 revoked. I also accept the responsibility for checking in with the clinic assistant to keep her informed of the use of my medication in case I start having problems.

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Student's Name	Student's Signature	Date
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I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above while at school. I accept legal responsibility should the above be lost, given, or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the DeKalb County School System and its employees of any legal responsibility when the above named student administers his/her own medication.

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Parent/Guardian's Name	Parent/Guardian's Signature	Date
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