School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Parental Authorization for Students to Carry and Self-Administer a Prescription Inhaler, EpiPen, Insulin, or Other Approved Medication School Year 20___ to 20___

___________________________ (student) needs to carry the following prescription labeled inhaler, Epipen, insulin, 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.

We strongly encourage each student to keep a second prescription inhaler, Epipen, additional insulin or other prescribed medication in the school health room in case of emergency and in the event the first is lost or left at home.

PARENT/GUARDIAN SECTION

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 and on field trips: ____.

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above name student.
    - I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Indian River County School District and its employees of any legal responsibility when the above named student administers his/her own medication.
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing provider if indicated.

________________________________	____________________________	_______________
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

STUDENT SECTION

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication under any circumstance. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept the responsibility for notifying the Health Assistant each time I take my medication.

____	_____________	_____________
Student's Signature	ID #	Date

Revised 02/06/2020