



### ADMINISTRATION OF EPIPENS AND/OR INHALERS

This completed form shall be on file for each child requiring an EpiPen or inhaler to be administered at school.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS : \_\_\_\_\_ PHONE: \_\_\_\_\_

HOMEROOM TEACHER: \_\_\_\_\_

#### **PARENT'S RELEASE FROM LIABILITY**

For and in consideration of allowing said child to attend school in spite of his/her specific health problem, we hereby release, relieve, and discharge St. Michael School and St. Michael Church Parish, the Diocese of Lafayette, and/or any of their agents or employees from any and all liability for any injury or damage to the said child arising out of, or related to, or resulting from the said child taking medication during school hours.

I have read, understand and agree to the school's regulations concerning giving medications at school.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

#### **THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN:**

1. Diagnosis \_\_\_\_\_

2. Medication Dosage and Route \_\_\_\_\_

3. When To Be Given \_\_\_\_\_

4. Reason for Medication \_\_\_\_\_

5. Possible Side-Effects and Contraindications \_\_\_\_\_

6. Duration of Medication Order will be for the school year of 2017-2018

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address of Physician City State Zip

#### **FORM MUST BE RE-SUBMITTED ANNUALLY**

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

ADMINISTRATION OF EPIPENS AND/OR INHALERS – Page 2

I have met with \_\_\_\_\_, Homeroom Teacher and demonstrated  
Child's name

how to administer the EpiPen and or inhaler.

Does your child's medical situation require your child to carry the EpiPen and an inhaler  
on their person?    Yes    or    No

If yes, please include a written order from your child's doctor.

I have also met with the Principal to explain my child's medical situation and to give the school  
the required signed medical forms and EpiPen and/or inhaler.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal Signature

\_\_\_\_\_  
Date