Please complete this form and return to Nurse Abby at abby.martin@usd340.org or Nurse Kelsey at kelsey.miller@usd340.org.

RELEASE TO CARRY EPI-PEN/AUVI-Q*

Name of Student: _____ Date of Birth: _____ School: _____ Grade: _____

Name of Medication: _____

TO BE COMPLETED BY PHYSCIAN:

The above-named student has been instructed in the proper use of their Epi-Pen/Auvi-Q*. I request that he/she be permitted to carry the Epi-Pen/Auvi-Q* at school or at school sponsored activities, as I consider him/her responsible. He/She understands the purpose, appropriate method, and frequency of use of the asthma inhaler.

***PHYSCIAN MUST PROVIDE A COMPLETED ALLERGY ACTION PLAN. MUST BE UPDATED ANNUALLY**

_____ _____ _____

Physician Signature | Physician (Printed Name) | Date

TO BE COMPLETED BY PARENT/GUARDIAN

The above-named student has my permission to carry and administer the above-listed medication as ordered by his/her physician. I understand that it is my responsibility to furnish this medication. I absolve the school of any responsibility in safeguarding our child's Epi-Pen/Auvi-Q*. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question.

_____ _____ _____

Parent/Legal Guardian Signature | Parent/Legal Guardian (Printed Name) | Date

TO BE COMPLETED BY STUDENT:

I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

_____

Student's Signature | Date

TO BE COMPLETED BY SCHOOL NURSE:

Student demonstrates knowledge/skill to carry and use the Epi-Pen/Auvi-Q.

_____ _____ _____

Date | Nurse/Designee Initial | School Nurse Signature

*or generic equivalent