Downingtown Area School District
Parent/Doctor Authorization to Carry Own Medication
Inhaler or Epi Pen/Twinject

Date: ___________

Student name _________________________ has been instructed in the proper use of the ______________________________. We request that the above named student be permitted to carry his/her medication or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. **He/she has been instructed in and understands the purpose, appropriate method and frequency of use of his/her medication.**

We the undersigned, absolve the school of any responsibility in safeguarding the misuse of our child's medication.

Please complete the following information:

Name of medication _____________________ Dose_____________________

For daily medication please note time of administration ________________________
If medication is to be taken **when needed**, describe indications:
____
How soon can it be repeated?____
List significant side effects ____
Date to stop medication____
Other information ____

In the event of self administration of an Epipen the student will inform a responsible person and 911 will be called. Epipen/ Twinject use needs to be reported immediately.

If inhaler is not effective in 10-15 min. student should report to the nurse with an escort or have the nurse summoned to their location.

_________________________________ _______________________________
Physician Signature | Parent Signature

_________________________________ _______________________________
Physician Phone Number | Parent Phone Number

Note: This form must be completed for those students who request permission to carry their own inhaler or Epipen/Twinject with them at all time and keep this medication in a P.E. locker. It is also suggested that a "back up" medication be kept in the nurse's office.

5/10