**PERMISSION TO CARRY EMERGENCY MEDICATIONS**

**Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TO BE COMPLETED BY THE PHYSICIAN:** The above‐named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child’s well‐being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication. *Students who are Pre-K-5th grade may have emergency medication kept in a secure location in the classroom with a physician’s signature.*

NAME OF MEDICATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN’S SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_

PHYSICIAN’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN:** I permit my child to carry the above‐listed asthma inhaler/emergency medication as ordered by his/her physician. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from 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 medications.

I also acknowledge the need to give permission for appropriate communications between the school health professional and the medical provider related to the specific treatment in question including communication concerning:

1. The prescription or treatment itself
2. Implementation of treatment at school
3. Student outcomes from the treatment
4. Other pertinent issues related to the students diagnosis, condition or treatment.

**PARENT/GUARDIAN SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_

**BACK-UP MEDICATION: It is recommended that back-up medication be provided to the school, for students who self-carry.**

* I will provide a back-up. **Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_
* I will not provide a back-up. **Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY SCHOOL NURSE:** Kansas law now permits students to carry and use inhaled medications/emergency medications after demonstrating appropriate use to school nurse. This student demonstrates knowledge / skill to carry and use the above listed asthma inhaler, epi-pen or other emergency medication. Or student understands roles necessary for emergency Glucagon or Diastat.

**SCHOOL NURSE SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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. I will keep it with me at all times.

**STUDENT’S SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_