PARENTAL AUTHORIZATION FOR STUDENT TO CARRY/SELF-MEDICATE PRESCRIBED ANTIHISTAMINE AND EPINEPHRINE

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Home Room Teacher: _____

List type and dose of antihistamine: _____

List type and dose of epinephrine: _____

Please check where the medicine will be kept:

_____ Student's Locker
_____ In student's backpack/purse
_____ Other: State location: _____

I understand that the Greeneville City School System shall not be held responsible or liable for the administration of the above listed medication. The parent/guardian releases the school district and its employees and agents from liability for any injury that may result from the student's self-administration of medication. It is the responsibility of the parent/guardian to make sure the child carries the medication on a daily basis as well as on field trips and other off campus activities. It is further understood that the authorizing physician has given proper instruction in the use of the above listed medication(s) to the parent and the student. The privilege of self-administering may be withdrawn if the medication is not used in the proper manner or is left unattended.

_____ _____
Parent/Guardian Signature Date

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

To be completed by student's healthcare provider:

Student Name: _____ Date of Birth: _____

I certify this child has a health condition requiring the use of antihistamine and/or epinephrine. The parent/guardian and child have been instructed on how to properly administer this medication and are competent to manage dosing and administration .

Name of Medication(s)	Dosage	Route/Frequency

Length of time medication is required: _____ Entire school year _____ Enter number of weeks

_____ _____ _____
Healthcare Provider's Signature Date Phone

Written: 08/08 Revised: 04/13