JOHNSON CITY SCHOOLS
HEALTH SERVICES
PARENTAL AUTHORIZATION FOR STUDENT TO CARRY/SELF-MEDICATE PRESCRIBED ANTIHISTAMINE AND EPINEPHRINE

Student's name: _____ Date of birth: _____

School: _____ Teacher: _____ Grade: _____ School Year: _____

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 – Please state location: _____

I understand that the Johnson City Schools 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. If 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 The privilege of self-administering may be withdrawn if the medication is not used in the proper manner or is left unattended.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: _____ Email Address: _____

********** TO BE COMPLETED BY STUDENT'S HEALTHCARE PROVIDER **********

Student's 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 ❑ _____ Number of weeks

_____ _____ _____

Physician's Signature Date Phone

PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE NEXT SECTION IF YOUR STUDENT IS

GOING TO CARRY AND SELF-ADMINISTER THE INHALER

FOR PHYSICIAN USE ONLY

- According to TN state law TCA 49-5-415 Students may carry and self-administer a prescribed asthma reliever inhaler under the following circumstances: the physician must provide the name, purpose, dose of medication, and the time(s) or special circumstances for use. The physician must further document that the student has been trained in the proper use of the inhaler.
- Physician signature indicates agreement with the plan and an order in good standing for the current school year.

_____ _____ may carry and self-administer the following metered dose asthma reliever medication by inhaler:
Name of student Date of birth

Name of Medication: _____

Purpose of Medication: _____

Time(s) or Circumstances when inhaler may be used: _____

_____

This student has been trained by a medical professional to independently use the metered dose inhaler: ❑ YES ❑ NO

Number of puffs allowed: _____

_____ _____ _____
Physician's Signature Date Phone

****Treatments, academic modification or activity restrictions will require separate written orders from the student's physician.**

I acknowledge that the school shall incur no liability and I indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the inhaler and my signature also indicates permission to notify staff of my student's individual health plan. I also give permission for the nursing department to contact my child's health care provider to obtain information or clarification regarding his/her medical condition. This consent form is binding for the entire school year unless I provide the school nurse with a written revocation.

_____ _____
Parent/Guardian Signature Date

If you have questions, please contact the Office of Health Services at 423-232-5380.

Form Updated 04/2018