



**AUTHORIZATION TO CARRY AND SELF ADMINISTER
ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT**

| | | |
|----------------------|-------|--------------------------------|
| Student Name (print) | | Parent / Guardian Name (print) |
| Student Number | Grade | Name of School |

Name of Medication: _____

To ensure the safety of all students, this form must be completed and submitted **annually** if your child is to carry and self-administer their own inhaler, epinephrine auto-injector, or pancreatic enzyme supplement (PES).

Section A: To Be Completed by a Florida-Licensed Healthcare Provider

I certify that _____ has been instructed in the proper use of the above-named medication(s) and/or procedure(s). In my professional opinion, this student is capable of responsibly carrying and self-administering the medication(s) or performing the procedure(s) as outlined in their Medical Management Plan (orders), without assistance. This student should be permitted to carry and use the specified medication(s) and/or equipment listed above.

Licensed Prescriber's Signature: _____ **Phone Number:** _____ **Date:** _____

Section B: To Be Completed by Parent/Legal Guardian

I request that my child be allowed to carry and self-administer the prescribed medication(s) while at school, during school-sponsored activities, and while traveling to and from such activities. My child has been properly instructed and understands the purpose, dosage, frequency, and method of using the medication(s).

My child acknowledges that:

- They are solely responsible for carrying and using their medication.
- The medication is for **their use only** and **will not be shared** with others. Sharing medication is a violation of the Student Code of Conduct and may result in disciplinary action.
- They will immediately inform a District School Board of Pasco County employee if another student uses their medication or if they experience any side effects, concerns, or questions.

I understand that if my child behaves irresponsibly or poses a safety risk, the **privilege** to carry their medication may be revoked. I acknowledge that the District School Board of Pasco County is not responsible for the maintenance, storage, dosage, replacement, or administration of my child's medication. I agree to indemnify and hold harmless the District School Board of Pasco County, its employees, and volunteers from any liability related to the use or misuse of the medication, in accordance with Florida Statutes § 1002.20(3)(h), (i), and/or (k).

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____