



## MARIAN CENTRAL CATHOLIC HIGH SCHOOL

1001 McHenry Avenue • Woodstock, IL 60098-3099

Phone (815) 338-4220 • FAX (815) 338-4253

### PARENTAL AUTHORIZATION FOR EPIPEN USE OR ASTHMA INHALER USE BY OR FOR STUDENT

1. The undersigned parent(s) or legal guardian(s) of \_\_\_\_\_  
is submitting a prescription or other written statement from my child's physician, physician  
assistant, or advanced practice registered nurse the following:

\_\_\_ Asthma inhaler/medication. The asthma prescription label or the written statement  
from the child's physician, physician assistant, or advanced practice registered nurse must  
contain the name of the asthma medication, the prescribed dosage, and the time at which  
or circumstances under which the asthma medication is to be administered,

\_\_\_ Epinephrine injector. The epi-pen prescription or the written statement from the child's  
physician, physician assistant, or advanced practice registered nurse must contain the  
name and purpose of the epinephrine injector, prescribed dosage; and the time or times at  
which or the special circumstances under which the epi-pen is to be administered.

2. I understand I must provide the epi-pen or the asthma inhaler/medication.
3. The prescription or other written statement from my child's physician, physician assistant,  
or advanced practice registered nurse permits my child, and I also permit my child, to:  
\_\_\_ self-administer and self-carry asthma inhaler/medication  
\_\_\_ self-carry of asthma inhaler/medication  
\_\_\_ self-administer and self-carry of an epinephrine injector  
\_\_\_ self-carry an epinephrine injector.
4. I also give permission for a school nurse or "trained personnel" to administer:  
\_\_\_ asthma inhaler/medication to my child  
\_\_\_ an epi-pen to my child  
in accordance with the instructions of the prescription or other written statement of my  
child's physician, physician assistant, or advanced practice registered nurse, and
5. I understand that I must complete this form and provide a new prescription or other written  
statement every school year if my child's need continues into a new school year.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_ Parent \_\_\_ Legal Guardian

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_ Parent \_\_\_ Legal Guardian