

TRINITY SCHOOL AT RIVER RIDGE

601 River Ridge Parkway

Eagan, MN 55121-2499

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Authorization for Student Possession and Self-Medication with Inhaler, Epi-Pen, and/or Insulin at School

Physician's/Dentist's Order

School Year _____

Child's Name: _____

Medication: _____

Dosage _____

Time/Frequency _____

Reason for Medication _____

Possible Side Effects _____

Estimated Termination Date _____

(All authorizations expire at the end of the school year.)

This student is knowledgeable about this medication and how to self-administer it (for inhalers and/or insulin) or how it should be administered (for Epi-pens).

Physician's Signature _____ Date _____

Address _____

Telephone Number _____

I request that my child be allowed to carry and self-administer medication with an inhaler and/or insulin at school or to carry an Epi-pen at school as prescribed by my child's physician/dentist. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it (and for an inhaler and/or insulin, self-administer it) at school.

Date _____ Parent/Guardian Signature _____