



**TRINITY SCHOOL**  
AT RIVER RIDGE

601 River Ridge Parkway, Eagan MN 55121-2499

Phone: 651.789.2890 FAX: 651.789.2891

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

**Physician's Order for Student and Self-medication**

School Year: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time/Frequency: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Estimated Termination Date: \_\_\_\_\_

This student is knowledgeable about this medication and how to self-administer the medication.

Physicians Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_



As authorized by my child's physician, I request that my child be allowed to carry and self-administer the prescribed medication noted above. I understand my child must carry this medication at all times in school or he/she will lose the right to carry and self-administer the medication at school.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_