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, 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_____

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