

ADMINISTRATIVE REGULATION 5150.0
Procedures for Administration and Recording of Medication
Churchill County School District

REQUEST TO CARRY AND SELF ADMINISTER
ASTHMA RESCUE INHALER OR EPINEPHRINE AUTO-INJECTOR

Student Name: _____ DOB: _____

School Site: _____ School Year : _____

Name of Medication: _____

The above referenced student is responsible for carrying and capable of self-administering the above medication. He/she understands the medication purpose and appropriate method of administration.

(Physician Signature) _____ (Date)

(Print Physician Name)

The undersigned parent/guardian hereby requests the Churchill County School District

allow my child, _____ to carry and self-administer

_____. The undersigned parent/guardian hereby expressly relieves the Churchill County School District, its Board of Trustees, and all agents of the District from any liability for the self-administration of this medication.

(Parent/Guardian Signature) _____ (Date)

(Print Parent/Guardian Name)

Reviewed By: _____
(School Nurse) _____ (Date)