



ST. JOSEPH SCHOOL

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SCHOOL-ADMINISTRATION OF MEDICATION FOR SCHOOL YEAR 2011-2012

A. Parent's/Guardian's Request and Authorization

I, the Undersigned, request and authorize St. Joseph School to administer to my child,

_____, his/her medication, **inhaler** and/or **auto-injectable epinephrine (EpiPen)**

Print Child's First and Last Name

Circle one or both as appropriate

while at St. Joseph School.

This authorization is given based on the following:

My child is not capable of and has not been instructed in the proper method of self-administration of this medication.

I, the Undersigned, understand that St. Joseph School, its employees or agents shall not incur any liability as a result of any injury arising from the school-administration of the medication to my child; shall exempt from liability and hold harmless school employees or agents against any claims arising out of the school-administration of medication to my child; understand that this authorization shall be effective for this current school year only and must be renewed annually.

Parent/Guardian Signature: _____ Date: _____

B. Physician's Certification

I, the Undersigned, certify that _____ has asthma, anaphylaxis or another

Student's First and Last Name

related potentially life-threatening illness, and he/she is not capable of and has not been instructed in the proper method of self-administration of his/her own **inhaler** and/or **auto-injectable epinephrine (EpiPen)**.

Circle one or both medication as appropriate

Physician's Signature _____ Date _____

Physician's Name _____

Please print