ST. JOSEPH PARISH SCHOOL
PROVIDING QUALITY CATHOLIC EDUCATION
94-651 FARRINGTON HIGHWAY WAIPAHU, HI 96797
TEL (808) 677-4475 FAX: (808) 677-8937
WEB: WWW.STJOSEPHWAIPAHU.ORG EMAIL: SJPS@STJOSEPHWAIPAHU.ORG

SCHOOL-ADMINISTRATION OF MEDICATION FOR SCHOOL YEAR _____

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

I, the Undersigned, request and authorize St. Joseph Parish 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 attending St. Joseph Parish 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 Parish 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-injectible epinephrine (EpiPen).**

Circle one or both medication as appropriate

Physician's Signature_____Date_____

Physician's Name_____

Please print