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

SELF-ADMINISTRATION OF MEDICATION FOR SCHOOL YEAR _____

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

I, the Undersigned, request and authorize my child, _____, to self-administer

his/her medication, **inhaler and/or auto-injectable epinephrine (EpiPen)** while at St. Joseph School.
(Circle one or both as applies)

This authorization is given based on the following:

My child is capable of and has been instructed in the proper method of self-administration of this medication. I understand that my child shall be permitted to carry at all times his/her medication as long as he/she doesn't endanger him/herself, or endanger other persons, and will not misuse the medication. I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the 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 self-administration of the medication by my child; shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child; understand that this authorization shall be effective for this current school year only and must be renewed annually.

Parent/Legal Guardian Signature:_____Date:_____

B. Physician's Certification

I, the Undersigned, certify that _____has asthma, anaphylaxis or another
(Student name)
related potentially life-threatening illness, and he/she is capable of and has been instructed in the proper method of self-administration of his/her own **inhaler and/or auto-injectible epinephrine (EpiPen).**
(Circle one or both as applies)

Physician's Signature_____Date_____

Physician's Name_____

Please print