Gibault Catholic High School

PARENT/GUARDIAN PERMISSION FOR SELF-ADMINISTRATION AND ADMINISTRATION OF AN INHALER BY SCHOOL EMPLOYEE

Student's Name:_____ DOB:_____

Address:_____ Grade:_____

Parent/Guardian Name:_____

Home Phone:_____ Other Phone(s):_____ _____

If Parent/Guardian is unavailable in emergency, contact:

Name:_____

Phone(s)_____ _____

Relationship to student:_____

My son/daughter has the following allergy(s) which may require treatment with an inhaler, according to my child's physician: _____

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CONSENT FOR TREATMENT

I give permission to allow my child to self-administer an inhaler or by the Gibault Catholic High School employee, by an unlicensed member of the school staff who has been trained in the event of an emergency.

_____ _____

Signature of Parent/Guardian Date

Gibault Catholic High School

PARENT/GUARDIAN PERMISSION FOR SELF-ADMINISTRATION AND ADMINISTRATION OF EPINEPHRINE (EPI-PEN) BY SCHOOL EMPLOYEE

Student's Name:_____ DOB:_____

Address:_____ Grade:_____

Parent/Guardian Name:_____

Home Phone:_____ Other Phone(s):_____ _____

If Parent/Guardian is unavailable in emergency, contact:

Name:_____

Phone(s)_____ _____

Relationship to student:_____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen), according to my child's physician: _____

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CONSENT FOR TREATMENT

I give permission to allow my child to self-administer epinephrine by auto-injection (Epi-pen) or by the Gibault Catholic High School employee, by an unlicensed member of the school staff who has been trained in the event of an emergency.

_____ _____

Signature of Parent/Guardian Date