



# Dorado Academy

## PARENT AUTHORIZATION FORM FOR SELF-CARRY OF EMERGENCY MEDICATIONS

Date (Valid for one School Year upon this date): \_\_\_\_\_

**Eligibility:** Only students in Grades 7th -12th with asthma, diabetes, and/or severe allergies who may require rescue medications like an inhaler, glucagon, insulin, epi-pen, and/or Benadryl.

Student's full name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade level: \_\_\_\_\_

I, (Please print parent's/guardian's names) \_\_\_\_\_  
parent/guardian of \_\_\_\_\_ authorize Dorado Academy to allow my child to  
self-carry and when applicable, to self-administer the following medications at school: \_\_\_\_\_  
\_\_\_\_\_

I accept full responsibility for my child being responsible for the aforementioned medication(s) and its proper use and safe keeping. I will ensure that my child is aware that the medication must be kept safe and with him/her at all times. All medications are to be provided by me, the parent, and must be valid and not past the expiration date. I/we, will meet with the school nurse prior to the start of school to provide all needed information, discuss the procedures, and present any concerns. In the event of an emergency, school personnel and the nursing office must be notified. If need be, I/we will supply back up supplies to the nursing office. By signing this document, I release and hold harmless Dorado Academy, its administration, faculty and all employees from all liability that may result from my child carrying this medicine at school.

**I/We submitted a doctor's note in support of our decision along with pertinent instructions:**

Date: \_\_\_\_\_

Demonstration of Self Administration: \_\_\_\_\_

Clear understanding of allergy triggers: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_