



**Manatee County School Health Services**  
**Contract to Carry and Self-Administer Asthma Inhaler,**  
**Epi-pen, Pancreatic Enzymes and/or Insulin/Diabetic Supplies**

\_\_\_\_\_  
Student Name (Print)

\_\_\_\_\_  
Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Name of School

**Medication:**      Epi-pen       Inhaler      Pancreatic Enzymes       Insulin/Diabetic Supplies

I hereby authorize the above named student to self-administer his/her inhaler/epi-pen/pancreatic enzymes/insulin or diabetic supplies while at school or on other School District property or at any School District sponsored activity. I understand and acknowledge that the School District assumes no responsibility whatsoever for the maintenance, storage, dosage, or administration of the above student's inhaler/epi-pen/pancreatic enzymes/insulin or diabetic supplies. I furthermore agree that to indemnify and otherwise hold harmless the School Board, its employees and volunteers for any and all liability with respect to the administration of the inhaler/epi-pen /pancreatic enzymes/insulin by the student.

The student also agrees as follows:

1. That the student understands what the medication is for, when to use it, and how often to use it.
2. That the medication is for their use alone and that they will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action.
3. That the student will immediately notify an adult working for the school or school district if any other student uses his / her medication.
4. That the student will immediately notify an adult working for the school or the school district if and when it becomes necessary for the student to self-administer the inhaler /epi-pen.
5. That the student will immediately go to the clinic or otherwise seek assistance if they continue to have problems after using inhaler, epi-pen or with diabetic medical management.

Self-administration of the above medication is a privilege – not a right. Abuse or misuse of medications will result in loss of the privilege to self-administer.

\_\_\_\_\_  
Parent / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date