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**Inhaler/Epi Pen/Auvi-Q Injector Self-Carry and Administration**

**Consent and Release**

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication: \_\_\_\_\_

**To Be Completed by Parent/Guardian:**

I permit my child to carry the above medication as ordered by her/his physician/healthcare provider. I understand that my child, not the school, is responsible for the storage, possession of the medication. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**To Be Completed by the Student:**

I understand the purpose, appropriate method, and frequency of the use of my above medication. I understand that I, not the school, is responsible for the storage and possession of the medication. I understand that sharing this medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_