MEDICATION AUTHORIZATION

SELF CARRY/SELF ADMINISTER FORM

A responsible, trained student may carry and/or self-administer medication for asthma (wheezing) or severe allergic (anaphylactic) reaction on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse, and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Date: _________________

STUDENT: _____________________________ BIRTH DATE: ______________ GRADE: _______

MEDICATION NAME: ____

DOSE: ______________________ METHOD OF ADMINISTRATION: _______________________

TIME/FREQUENCY: __________________________________

DURATION (DATES) OF ADMINISTRATION: FROM: __________ TO: __________ (LIMIT OF ONE SCHOOL YEAR)

DIAGNOSIS: ____

PRECAUTIONS, INTERVENTIONS, COMMENTS: _______________________________________

____

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

_________________________ ________________ ________________ ________________

Physician's Signature Print Name Phone # Fax #

____

Address

____

City, State, ZIP

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and does of medication; and directions for use. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.

________________________ ____________ ________________________ ____________

Parent Signature Date Student Signature Date

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. We will contact the parent as soon as possible in this event.

________________________ ____________ ________________________ ____________

School Nurse Signature Date Principal Signature Date