AUTHORIZATION FOR STUDENTS TO SELF-CARRY

Please fill out and complete all four sections.

Student's name _____ **School year** _____

To be Completed by Prescribing Health Professional

It is my professional opinion that _____

is capable of carrying and self-administering the following medication:

Medication name _____

Dosage _____

Frequency _____

I recommend self-administration of this medication for the treatment of:

_____

Special Instructions or Comments _____

_____

HEALTH CARE PROVIDER SIGNATURE DATE

_____

PRINT NAME PHONE

To Be Completed by Parent/Guardian

I, request and authorize my child _____ to carry

and/or self-administer their _____ medication.

This authorization is given based on the following:

- I hereby give permission for my child to self-administer prescribed medication at school.
- I authorize release of information related to my child's health/medications between the school nurse and the prescribing healthcare provider.
- I understand that my child shall be permitted to carry their medication at all times providing they do not misuse the medication.
- I understand that if my child misuses the medication, school employees will take the medication and terminate this agreement.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINT NAME PHONE

Continued on the back side

To Be Completed by Licensed School Nurse

☐ The student can demonstrate correct use/administration.
☐ The student can recognize correct dosage.
☐ The student recognizes prescribed timing for medication.
☐ The student agrees to not share the medication with others.
☐ The student will keep a second labeled container in the health office.

The student (is/is not) able to demonstrate the specified responsibilities. The student (may/may not) carry the prescribed medication.

LICENSED SCHOOL NURSE NAME (PLEASE PRINT)

SIGNATURE DATE

To Be Completed by the Student

I, _____ agree to the responsibilities of carrying medication. I have been trained in the proper use of my prescribed medication and understand how it is given. I will keep this medication with me at all times and take my responsibility to self-carry seriously. I also understand that if I misuse my medication, this agreement will end.
If I take my medication I will contact the school nurse.

STUDENT NAME (PLEASE PRINT)

STUDENT SIGNATURE DATE