Benton Elementary
Ph: 574-831-2192 Fax: 574-831-2200
Fairfield Jr-Sr High
Ph: 574-831-2184 Fax: 574-831-2187

Fairfield Community Schools
HEALTH SERVICES

Millersburg Elem. & Middle
Ph: 574-642-3074 Fax: 574-642-3918
New Paris Elementary
Ph: 574-831-2196 Fax: 574-831-3160

EMERGENCY SELF-ADMINISTERED MEDICATION AUTHORIZATION
2020 - 2021

Student's Name_____**Grade**_____

Health Care Provider (HCP) Name _____ **HCP Phone**_____

Authorization from a Health Care Provider (below) is required each school year for a student to carry and self-administer emergency medication (Inhalers /Epinephrine auto-injector/EpiPen, diphenhydramine) at school and/or at school-related activities. Medication must be in the original container, and include Pharmacy Label instructions. ***PLEASE NOTE:*** *It is the responsibility of the parent/guardian to maintain a supply of the medication for the student, and it is recommended that additional emergency medications be kept in the school clinic in case the child fails to self-carry their medication.*

HEALTH CARE PROVIDER AUTHORIZATION

This certifies that the above named student has an acute or chronic disease that may require the emergency self-administration of the following prescription medication:

Name of medication_____

Dose _____Frequency _____Route: ☐ Inhaled ☐ Injected ☐ Oral

Please allow this student to possess and self-administer this medication during attendance at school and/or during school-related events. This student has been instructed on how to properly self-administer this medication.

Please list additional instructions or comments: _____

_____

_____ _____

Health Care Provider Signature Date signed

STUDENT AUTHORIZATION

I understand that all medications are to be kept in the nurse's office unless there is a written statement from the HCP authorizing the use of emergency self-administered medication. I affirm that I will: (Please initial each below)

_____use this medication only when it is needed
_____not allow anyone to use or carry this medication
_____ notify the school nurse (during school hours) or a responsible adult (at school activities) if there is *no* marked improvement in my symptoms within several minutes after using my medication
_____immediately notify the school nurse during school hours, or a responsible adult at school activities if I use my EpiPen
_____immediately report to the school nurse or a responsible adult if my medication is lost or stolen

I understand that if I do not follow the policies listed above, disciplinary action or revoking this privilege will result.

_____ _____

Student's Signature **Date signed**

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PARENT AUTHORIZATION

As parent/guardian of the child listed above, I request that my child be permitted to possess and self-administer the medication/s listed above according to school policy. I understand that my child, not school personnel, is responsible for this medication, and the school is not liable if it is abused, lost or stolen. I agree to notify the nurse immediately of any changes in circumstances concerning the administering of this medication, or of any changes in my child's health status. I understand that if my child does not comply with the Student Authorization policies listed above, this privilege may be revoked. I release school personnel from all liability in allowing my child to self-administer this medication.

_____ _____

Parent/Guardian's Signature **Date signed**