

EMERGENCY SELF-ADMINISTERED MEDICATION AUTHORIZATION 2021 - 2022

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 signature _____ date _____

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