

**UEJ QQN'FKVTKV'QHJ CXGTHQTF "VQY PUJ IR
TGS WGUV'HQT'UGNH'CF O KPVTKVQV'QHGO GTI GPE['O GF KCVKQP "**

Physician's Order

Parent/Guardian Request

Please allow the following emergency medication to be carried and self administered on school property. This patient has demonstrated the capability to safely administer his/her own medication.

I request that my child _____ be allowed to carry and self-administer his or her own emergency medication as prescribed. I relieve the school or any school district employee of any responsibility for the benefits or consequences of this self-administered medication, and understand that the school or employees bear no responsibility for ensuring that the medication is taken.

Name of Patient _____

Signature of Parent/Guardian _____

Name of Medication _____

Date _____

Dose _____

When Administered _____

Directions for Administering _____

SDHT Emergency Medication Policy

Possible Side Effects and Treatment

- This form must be kept on file in the nurse's office.
- After self-administering the medication, the student must immediately notify the school nurse and sign his/her medication sheet in the presence of the nurse.
- Prescription medication orders must be renewed each year. Medication forms expire at the end of the current school year.
- The medication carried by the student must be clearly labeled with the student's name.
- If the medication is misused by the student to whom it is prescribed, shared with other students, or improperly safeguarded from abuse by other individuals, the privilege to carry the medication will be revoked.

Date Prescribed _____

Signature of Physician _____

Name of Physician _____

Address of Physician _____

Phone Number _____