Faith Christian Academy
AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND SCHOOL ACTIVITIES

Policy permits a responsible, trained student to carry/self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes with a written order from physician, parent request, and nurse approval.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Name of Student _____ Date _____ D.O.B. _____

Condition for which the medication is administered _____

Name of medication, dose and method administered _____

Time and indication for administration _____

Side effects to be noted/reported _____

Other recommendations _____

Duration (dates) of administration: From _____ to _____(limit of one school year)

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

Physician Signature_____ Date_____

* Please also provide an Emergency Care Plan for Student

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry/ self-administer the above ordered medication. I understand that the medication must be in the original pharmacy container, labeled with the name of the student and prescribing health care provider. I acknowledge that Faith Christian Academy bears no responsibility for ensuring that the medication is taken. I agree to release Faith Christian Academy and all school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of their ordered medication.

Parent Signature_____ Date_____