CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Authorization to Carry/Self-Administer Medication

Pursuant to the laws of the Commonwealth of Kentucky and Campbell County Schools Board Policy, students may be Granted permission to carry and self-administer medication for use as needed during school hours and during school sponsored activities. This is limited to medication for treatment of asthma, severe allergic reaction, or diabetes. The student must have training in the proper use and administration of the medication named and be responsible for safe use.

Student Name: ______________________________ Date of Birth: ____________

School: ______________________________ Grade: ________ Teacher: ____________________

Condition for which Medication is Prescribed: ______________________________

Medication Name: ____________________ Dosage: ____________ Route of Administration: ________

Time/Frequency of Administration: ____________________ If PRN (as needed) frequency: ____________

If PRN (as needed), for what observable signs/symptoms: ______________________________

Possible/Relevant Side Effects: ______________________________

Additional Instructions/Follow Up: ______________________________

****This student has been instructed on self-administration & shows capability to carry and self-administer this medication. He is authorized to do so in school****

Physician Signature: ____________________ Printed Name: ____________________
Phone Number: ____________________ Date: ____________________

Parent/Guardian Authorization

I request that my child be permitted to carry and self-administer the medication ordered above. I understand the medication must be in its original prescription container. I accept responsibility for this permission and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school and its employees/agents, harmless against any claims relating to the self-administration of such medication.

Parent Signature: ______________________________ Date: ____________________