AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER SCHOOL ACTIVITIES

Board of Education policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student____Date of Birth________________________

Address____Grade____________

Condition for which the medication is administered____

Name of medication, dose and method administered____

Time or indication for administration____

Is this a controlled drug? ______Yes _____No

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 Print Name Telephone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to _____ carry _____self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication name, date of original prescription, strength and dose of medication, and directions for use. I will also provide extra medication with a Physician Authorization Form to be kept in the school clinic for emergencies. No more than a 45 school day supply of medication will be kept at school.

I am the parent/guardian of the child named above and I am acting on my own behalf and on behalf of this minor child. We hereby authorize and agree to hold the Avon Community School Corporation and its officers and employees harmless for the administration of this medication.

I understand that by operation of law, specifically Indiana Code 34-30-14-2, an Avon Community School Corporation employee or staff member administering medication in accord with the permission statement and the Avon Community School Corporation shall be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document, except in the case of gross negligence or willful and wanton misconduct.

In addition to the immunity described above, in exchange for Avon Community School Corporation's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.

____ _____________ ____ ________________
Parent Signature Date Student Signature Date

____
Parent Phone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

____ ______________ ____ _______________
School Nurse Signature Date Principal Signature Date