Greenville ISD Health Services
Emergency Medication Self-Carry Agreement

This plan is in accordance with FFAC (LEGAL) This policy allows students to self-administer emergency rescue medication while at school or school functions with permission from parents, physicians, and the school nurse. This form is good only for the current school year and must be completed at the beginning of every school year.

Student Name: Grade DOB

Address:

Parent/Guardian: Phone# Phone#

Emergency Contact: Phone# Phone#

Treating Physician: Phone#

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY STATE OF TEXAS

□ I have instructed_____(student's name) in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the following emergency rescue medication while on school property or at school-related events:

Rescue Medications

Name:	Purpose:
Dosage:	When to Use:
Name:	Purpose:
Dosage:	When to Use:

For asthma inhalers only! **May repeat for severe breathing difficulty____times____minutes apart.**

Physician Signature_____Print Name_____

Date_____ Office Number _____ Fax Number _____

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her emergency rescue medication while on school property or at school related events according to school district policy and the student agreement below. I authorize the school's licensed nurse and the prescribing physician to discuss and/or clarify this medication order, or in the interest of this student's health, to discuss his/her response to the prescribed medication as required by the Nurse Practice Act and Medical Practice Acts of Texas.

Parent/Guardian Signature_____Date: _____

C. TO BE COMPLETED BY STUDENT AND SCHOOL NURSE

____ Student knows name, correct dosage, purpose, expected effects and side effects of medication.
____ Student demonstrates correct use/administration of medication.
____ Student understands that medication must have prescription label affixed, be used only in accordance with instructions on prescription label ,that allowing anyone else to use this medication will result in disciplinary action, and that the PRIVILEGE of carrying this medication can be rescinded for violating any part of this agreement.

Student will carry/keep medication_____
Specify location

_____ _____ _____

Student Signature School Nurse Signature Date