MARPLE NEWTOWN SCHOOL DISTRICT

Medication Self-Carry Form

Health Services policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on their 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

Student's Name: _____ DOB: _____

School: _____ 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 or No) _____

Side effects to be noted/reported. _____

Other recommendations: _____

Duration Dates of Administration (Limit of 1 school year)_____

In my opinion, this student shows capability to carry and self-administer the above medication.

Physician Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Parent / Guardian Authorization

I request that my child, named above, be permitted to carry and 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 the name of the student, medication, prescribing health care provider, date of the original prescription, strength and dose of medication, and directions for use.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Parent Phone Numbers _____

We accept the parent request and physician statement. We acknowledge that the student has demonstrated they are capable of self-administration and/or use of equipment. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student displays irresponsible behavior or there is a safety risk. If this is the case, we will contact the parent as soon as possible.

School Nurse Signature: _____ Date: _____

Principal Signature: _____ Date: _____