



Emergency Self-Medication Authorization Form

When complete, please return this form to the school nurse at **Fayetteville Academy**.

910.868.7351 (Fax) 910.868.5131 x.3323 (Phone) Katherine Vantias kvantias@fayacademy.org

School Year: _____	Teacher/Grade: _____
Student Name: _____	Birthdate: _____
Medication: _____	Dose/Route _____
Time Interval: _____	

Under which conditions should medications be administered?

I verify that the student has asthma or an allergy that could result in an anaphylactic reaction, or both, and that I, the health care practitioner, prescribed medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

I prescribed the asthma and/or allergy medication and I confirm that the student has been instructed in self-administration of the prescribed medication. The student has demonstrated the skill level necessary to use the asthma and/or allergy medication and any device that is necessary to treat their symptoms.

Physician's Signature	Phone Number	Date

I have read the guidelines for students with emergency self-medication in their possession at school and I judge that my child named above has sufficient maturity and knowledge to safely and correctly self-medicate.

I understand that my child must comply with the following:

- The student must keep the medication in his/her possession at all times and shall not leave it in a place accessible to other students.
- The student shall not offer, nor allow any use of his/her emergency medication by another student.
- The student shall act in a responsible and discreet manner concerning his/her emergency medication.

I understand that if my child has significant difficulty with their medication (i.e. asthma) requiring repeated use of inhaled medication; they shall not continue to use the medication in place of getting appropriate medical care. I also understand that backup medication must be provided to the school within 14 calendar days of this authorization.

I further understand that the only liability that the school can assume is to comply with the terms of this protocol. I understand that the school can assume no liability for monitoring self-administration, including the frequency and dose or failure to self-medicate when necessary.

I consent for the health care practitioner to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except for the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing for the term of one year. I have read and agree with this authorization and have provided the school backup emergency medication for my child.

Signature of Parent/Guardian	Date	Parent Printed Name
FOR SCHOOL NURSE USE ONLY		

This student has demonstrated the skill level necessary to use emergency medication or device.

Signature of School Nurse	Date	Administrator Signature	Date
Date Emergency Self-Medication Form Expires (1 year from physician's signature)		Date: _____	