

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

Orange County School Board policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic reaction, diabetes, or other life threatening illnesses, on their person for immediate use in a life threatening situation, with a written order from a licensed prescriber, parent consent, and school nurse approval.

LICENSED PRESCRIBER ORDER

Student Name: _____ **DOB:** _____ **Grade:** _____

School: _____ **Diagnosis for Medication:** _____

Medication Name: _____ **Dose:** _____ **Route:** _____

Frequency: _____ **Controlled Medication? (please check one):** _____ **YES** _____ **NO**

Side effects to be reported: _____

Additional prescriber recommendations: _____

Duration of Administration: From _____ to _____, *within current school year.*

Prescriber Signature: *In my opinion, the above listed student demonstrates capability to carry and self administer the above listed medication. The above listed student has been trained on how to properly administer this medication.*

Prescriber Name (please print): _____ **Prescriber Signature:** _____





Telephone number: _____ **Date:** _____

PARENT/GUARDIAN CONSENT

Parent/Guardian Authorization: *I request that my child, named above, be permitted to carry and self administer the above ordered medication by their licensed prescriber. I take responsibility for this permission. I understand that this medication must be in its original, labeled medication container. Failure to responsibly carry or administer this medication will result in revocation of the ability to self carry this medication during school hours.*

Parent Name (Print): _____ **Parent Signature:** _____

Date: _____

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