

**Gilbert Public Schools**

**Authorization for Students to Self-Carry Emergency Medication**

*A new form must be completed each school year. Form to be kept in the Health Office.*

School Year \_\_\_\_\_ - \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

**THE MEDICATION IDENTIFIED ON THIS FORM MUST BE BROUGHT IN THE ORIGINAL CONTAINER APPROPRIATELY LABELED BY A PHARMACIST WITH THE STUDENT'S NAME. THE CONTAINER MUST DUPLICATE THE DIRECTIONS GIVEN ON THIS REQUEST.**

**THIS AREA MUST BE COMPLETED BY PARENT / GUARDIAN**

Name of medication to be given \_\_\_\_\_

Purpose of the medication \_\_\_\_\_

Frequency of use \_\_\_\_\_ Prescribed dosage to be given at school \_\_\_\_\_

Time(s) or circumstances medication is to be administered \_\_\_\_\_

Side effects of the medication, if any \_\_\_\_\_

Other medication(s) student is receiving \_\_\_\_\_

Inhaler Yes \_\_\_\_\_ No \_\_\_\_\_

\*Epinephrine Injector Yes \_\_\_\_\_ No \_\_\_\_\_

Diabetic Supplies / Medication (Be Specific) \_\_\_\_\_

\*Glucagon (must be administered by designated person) - Yes \_\_\_\_\_ No \_\_\_\_\_

\*911 will be called if Epinephrine or Glucagon has been used.

*I understand the above named student is responsible for keeping the medication and / or equipment and supplies safely on his or her person. An extra supply of the medication should be kept in the Health Office for emergency use. The student should come to the Health Office in the event of an emergency, if it is possible. The District is not responsible for any loss of medication. The student is expected to adhere to the District Policy regarding medications.*

*I do give permission to the School Nurse to contact the Medical Provider regarding the medication.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Printed name of parent/guardian                      Signature                      Date

\_\_\_\_\_  
Printed name of emergency contact for student                      Emergency contact number

\_\_\_\_\_  
Printed name of medical provider                      Provider contact number                      Provider fax number