Authorization to Carry Prescribed Emergency Medication

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use the following prescription emergency medication(s) at school:

▢ **epinephrine auto-injector** ▢ **albuterol inhaler** ▢ **insulin** ▢ **glucagon** ▢ **Diastat** ▢ **other:**

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(Student Health Services strongly encourages each student to keep a second prescription inhaler, Epipen, additional insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)

- I have provided the health clinic with a medical care plan, completed by my prescribing physician that states my student should be allowed to carry this medication independently;
- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container;
- I release Lee County School System (LCSS) and its employees of any legal responsibility when supervising or assisting in this medication administration or when the above named student administers his/her own medication (to include choking, allergic reaction, side effects and/or health risks related to this medication);
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing healthcare provider if indicated or needed.

_____ _____

Parent/Guardian Signature *Date*

To Be Completed by Student:

- I have been instructed by the prescriber in the proper use of my labeled medication and fully understand how it is administered.
- I will keep this medication with me and on my person at all times.
- I will not allow another student to use my medication and/or medical supplies under any circumstances. I also understand that should another student use my prescription medication, the privilege of carrying my medication may be reassessed and/or revoked.

_____ _____

Student Signature *Date*