

Authorization Form For Student to Carry Prescribed Inhaler, EpiPen, Insulin, or Another Approved Emergency Medication

Child's Name: _____

Date of Birth: ____/____/____

Circle School: Lower Middle Upper/CA

Known Food or Drug Allergies: _____

***** This form needs signatures from physician, parent, and student***

Mills Springs Eligibility Requirements for Self-Medication/Self-Carry

Students with chronic conditions such as asthma, diabetes, severe allergies, and those who require frequent doses of non-prescription products, may be eligible to self-medicate. For self-medication, students:

1. Must be mentally, emotionally, and physically capable of self-administering medication
2. Must have been instructed in proper use and safe-keeping of their medications
3. Must demonstrate mature and responsible behavior using their medication
4. Must keep their medication secure on their own person or in some other manner agreed upon with the school nurse and the school administration
5. Must not share medication with or display to other students.

PARENT/GUARDIAN

My child is capable of self-medicating and meets the Mills Springs eligibility requirements. I give consent to Mills Springs Academy to allow my child to self-administer and carry this medication at school. I request that my child be allowed to carry and self-administer this emergency medication. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given to or taken by a person other than the above named student. I release, Mill Springs Academy, and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her asthma medication.

- ☐ The physician provided the parent/guardian with a written emergency/management plan including the name, purpose, dosage, and administration directions of the medication

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Parent/Guardian Telephone _____

Date (mm/dd/yyyy) _____

PHYSICIAN

The above named student may carry and/or self-administer the following medication device as outlined below (please mark all boxes that are applicable and initial to the right of all marked boxes).

Metered Dose Inhaler (MDI)	☐ Student may carry	☐ Student may self-administer	Initials:
Epinephrine for Severe Allergy	☐ Student may carry	☐ Student may self-administer	Initials:
Pancreatic Enzyme Supplement/Diabetic Support/Insulin	☐ Student may carry	☐ Student may self-administer	Initials:
Other: Describe Below	☐ Student may carry	☐ Student may self-administer	Initials:

Physician Printed Name _____

Physician Signature _____

Date (mm/dd/yyyy) _____

Telephone: _____

STUDENT

I have been instructed in the proper use of my prescription labeled medication and fully understand how and when to use this medication. I will carry my medication with me at all times and will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of the use of my medication.

Student's Printed Name _____

Student's Signature _____

Date (mm/dd/yyyy) _____