



**PHYSICIAN AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF EPINEPHRINE,
INHALERS, OR DIABETIC MEDICATIONS AT SCHOOL/SCHOOL ACTIVITIES**

Name of Student: _____ Date: _____ D.O.B: _____

Condition for which the medication is administered: _____

Name of medication: _____

Time dose, and route of administration: _____

Side effects to be noted/reported: _____

Dates of administration: From _____ To: _____ (limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER
THE ABOVE MEDICATION.

Physician Signature _____ Date _____

* Please also provide an Emergency Care Plan for Student

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry/ self-administer the above ordered medication. I understand that the medication must be in the original pharmacy container and labeled with the name of the student/prescribing health care provider. I acknowledge that Faith Christian Academy bears no responsibility for ensuring that the medication is taken. I agree to release Faith Christian Academy and all school personnel from all claims of liability if my child suffers any adverse reactions from self-administration privileges. * Please return both the physician order form and the following Parent/Student agreement.

Parent Signature _____ Date _____



Student Agreement Regarding Self-Administer/Carry

- I have demonstrated proper self-administration and use to my physician and parent/guardian.
- I agree to never share medication with anyone else.
- I agree to let a teacher know immediately if I need to use my epi-pen so they can contact the nurse.
- I agree to report each occasion of inhaler use to the nurse.
- I agree to come directly to the Nurse Office if I continue to have difficulty breathing, wheezing, or chest tightness after using my inhaler.
- I will let my teacher know if my blood sugar is too high or low so they can immediately contact the nurse.

Student Signature _____ Date _____

Parent/Guardian Agreement Regarding Self-Administration/Carry

- My child will be responsible for carrying his/her own medication. He/she has demonstrated proper self-administration and use to me and his/her physician. My child agrees to follow the school's procedure concerning the handling and administration of the medication.
- I understand that it would benefit my child for the nurse to be supplied with back up medication in the event the medication is lost, forgotten, or misplaced.
- I acknowledge that Faith Christian Academy bears no responsibility for ensuring that the medication is taken.
- I agree to release Faith Christian Academy and all school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of their medication.

Parent/Guardian Signature _____ Date _____