



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Indication: \_\_\_\_\_

**HEALTHCARE PROVIDER AUTHORIZATION**

By signing below, I attest that:

- ❖ This patient/student has asthma or anaphylaxis and has demonstrated the skill level necessary to self-administer the prescription medication listed above.
- ❖ I have also completed the district medication authorization form detailing the prescribed medication's name, purpose, dosage, indication, and period for which the medication is prescribed.

HCP Printed Name and Credentials: \_\_\_\_\_

HCP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PARENT AUTHORIZATION AND ACKNOWLEDGEMENT**

By signing below, I attest that:

- ❖ I am requesting that the school staff allow my child to carry their prescribed medication with the intention of self-administration while on school property or at school related events/ activities.
- ❖ My child is capable of administering the medication listed above independently as ordered by the healthcare provider. I understand that the school nurse will not be able to monitor the administration dose and frequency of a self-carried medication.
- ❖ I understand that this permission may be revoked in the event that a safety risk related to the self-management of emergency medication is identified by HISD staff.

Parent/Guardian Printed Name: \_\_\_\_\_

Parent Guardian Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**STUDENT ACKNOWLEDGEMENT**

By signing below, I agree that:

- ❖ I can and will safely and appropriately administer my medication as ordered by my healthcare provider.
- ❖ I understand it is for my use only and not to be shared with peers. I will immediately notify a school staff member if my medication is lost or stolen.
- ❖ I understand it is my responsibility to notify a school staff member/ adult if my medication supply is not adequate and/or I need medical assistance.

Student Name: \_\_\_\_\_ Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**SCHOOL NURSE ASSESSMENT AND AUTHORIZATION**

Based on my assessment on \_\_\_\_\_ (DATE) I attest that:

- ❖ This student has demonstrated the skill level necessary to self-administer the prescribed medication, including any applicable delivery device.
- ❖ This student is able to identify the signs and symptoms that indicate need for this medication and is able to identify the expected outcome and side effects after use.
- ❖ This student is able to verbalize how he/she should respond if an unexpected outcome occurs.

This student will be permitted to carry the above stated medication for the 20\_\_-20\_\_ school year. The district reserves the right to withdraw permission if the student shows signs of irresponsibility or in the event that a safety risk is identified. If permission is withdrawn, the parent/guardian will be notified as soon as possible.

School Nurse, Credentials: \_\_\_\_\_ Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

