

HEALTH REQUIREMENTS AND SERVICES  
MEDICAL TREATMENT

FFAC  
(EXHIBIT)D

STUDENT WITH PEANUT AND OTHER ALLERGY --  
SELF ADMINISTRATION WITH EPINEPHRINE OR OTHER MEDICATIONS

Student Name: \_\_\_\_\_ ID: \_\_\_\_\_ Birth Date \_\_\_\_\_

Campus: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Medication administered to a student at school shall be under the supervision of an appointed school employee or the student's parent/guardian. However, a student may maintain possession of prescribed medication for allergy related conditions and self administer the medication only with formal requests of the student's physician and parent/guardian, and assessment of proper use and care of his/her prescribed medication by the school nurse.

STATEMENT OF PHYSICIAN:

I have determined the above named student should always have the following specific medication

\_\_\_\_\_ (epinephrine delivery system or oral allergy medication for use during emergency reaction) personally available always while at school with other personal items I have instructed the student in proper disposal of needles. I have explained state and federal laws and regulations regarding potential blood exposure to classmates and/or school personnel and I have determined that the student has the maturity level and is responsible to properly maintain all supplies, appropriate and proper use of the medication.

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

STATEMENT OF PARENT/GUARDIAN:

I have determined that my student has received and understands the instructions on the proper use of above named medication. I further declare he/she is capable and trustworthy to be responsible in the appropriate and proper use of the medication, and will always not abuse the right to have the medication in his/her possession. I understand that my student, not the school is responsible for the storage, possession, and use of above-named medication. I also understand that unauthorized use will result in the medication being stored in the school health office and administered according to the Administrative Regulation FFAC, and that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Statement of Student:

Ector County ISD  
068901

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I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, am responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Statement of Nurse:

The above-named student has demonstrated the proper use and care of his/her above-named medication for the campus nurse.

School Nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_