Gilbert Public Schools

Authorization for Students to Self-Carry Emergency Medication

A new form must be completed each school year. Form to be kept in the Health Office.

School Year _____ - _____

STUDENT NAME _____ DATE OF BIRTH _____/_____/_____

SCHOOL _____ GRADE _____

THE MEDICATION IDENTIFIED ON THIS FORM MUST BE BROUGHT IN THE ORIGINAL CONTAINER APPROPRIATELY LABELED BY A PHARMACIST WITH THE STUDENT'S NAME. THE CONTAINER MUST DUPLICATE THE DIRECTIONS GIVEN ON THIS REQUEST.

THIS AREA MUST BE COMPLETED BY PARENT / GUARDIAN

Name of medication to be given _____

Purpose of the medication _____

Frequency of use _____ Prescribed dosage to be given at school _____

Time(s) or circumstances medication is to be administered _____

Side effects of the medication, if any _____

Other medication(s) student is receiving _____

Inhaler Yes_____ No _____

*Epinephrine Injector Yes_____ No _____

Diabetic Supplies / Medication (Be Specific) _____

*Glucagon (must be administered by designated person) - Yes _____ No_____

*911 will be called if Epinephrine or Glucagon has been used.

I understand the above named student is responsible for keeping the medication and / or equipment and supplies safely on his or her person. An extra supply of the medication should be kept in the Health Office for emergency use. The student should come to the Health Office in the event of an emergency, if it is possible. The District is not responsible for any loss of medication. The student is expected to adhere to the District Policy regarding medications.

I do give permission to the School Nurse to contact the Medical Provider regarding the medication.

_____ _____ _____/_____/_____

Printed name of parent/guardian Signature Date

_____ _____

Printed name of emergency contact for student Emergency contact number

_____ _____ _____

Printed name of medical provider Provider contact number Provider fax number