



## Self-Carry and Administration Form for Emergency Medications

*Must be accompanied by a Prescription Medication Authorization Form*

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose and Time/Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose and Time/Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose and Time/Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose and Time/Frequency: \_\_\_\_\_

The student's name must appear on the medications and/or devices. This form is valid from the date of signing until the end of the school year.

### Parent Authorization

*I hereby release Carolina Day School and their agents and employees from all liability that may result from my child taking the prescribed medication(s). Please check all that apply.*

- ☐ *I agree to allow my child to bear the responsibility of carrying the medications listed above.*
- ☐ *I agree to allow my child to bear the responsibility of self-administering the medications listed above.*
- ☐ *My child is able to demonstrate proper use and care of the medications listed above.*

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Student Responsibilities

- ☐ *I plan to keep my inhaler/equipment, epinephrine auto-injector, or diabetes medication/equipment with me at*
- ☐ *school and off-campus school functions;*
- ☐ *I agree to use my inhaler/equipment, epinephrine auto-injector, or diabetes medication/equipment in a responsible*
- ☐ *manner, in accordance with my licensed health care provider's orders.*
- ☐ *I will notify the school staff (i.e. teacher, nurse) if I am having more difficulty than usual with my health*
- ☐ *condition.*
- ☐ *I will not allow any other person to use my medication or equipment.*
- ☐ *I will keep my inhaler/EpiPen in the following location (locker/backpack etc) \_\_\_\_\_*

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_