Authorization For Student to Carry Emergency Medication

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

For purposes of this authorization, emergency medication may include inhalers, epinephrine, insulin and other diabetes supplies, emergency seizure medications, and other prescribed emergency medications. This authorization is valid only when a corresponding school action plan is on file with the school.

Forsyth County Schools acknowledges that a student authorized to carry emergency medication may not be able to self-administer the medication due to age, cognitive ability, medical condition, or the nature of the emergency. In such cases, school personnel may administer the medication as prescribed. *It is recommended that a backup supply of the medication be maintained in the school clinic.*

LICENSED PRACTITIONER AUTHORIZATION

The above-named student requires the following prescribed emergency medication at school:

Medication Name: _____

Purpose/Condition(s): _____

Dosage and Instructions: _____

I certify that this student has been instructed in the proper use of the prescribed medication and understands how to administer this medication, if able.

- ☐ May self-carry and self-administering the listed medication.
- ☐ May self-carry the listed medication but is not capable of self-administering; assistance with administration is required.

Licensed Practitioner Name (PRINT): _____

Licensed Practitioner Signature & Credentials: _____

Date: _____

STUDENT AGREEMENT

I have been instructed in the proper use of my prescription-labeled medication and understand when it should be used and how to administer it.

I understand that I may not share my medication with any other person and that misuse of any kind may result in loss of the privilege to carry and/or self-administer medication at school. I will notify the school nurse or designated school personnel each time I take my medication, when appropriate.

Student Signature: _____ Date: _____

PARENT/GUARDIAN CONSENT

I request that the above-named student be permitted to carry and use the prescribed medication at school.

I release and hold harmless Forsyth County Schools, its employees, and officials from any and all liability when my student carries and/or self-administers medication in accordance with this authorization including any medication that is lost, shared with, taken by another person. I understand and agree that any misuse of the medication may result in loss of the privilege to carry and self-administer medication at school.

Parent Name (PRINT): _____

Parent Signature: _____ Date: _____