

STUDENT MEDICATION SELF-CARRY & SELF-ADMINISTRATION AUTHORIZATION

(Including Asthma, Anaphylaxis, Diabetes, or Other Emergency Medications only)

Student Name: _____ Date of Birth: ____ / ____ / ____

School: _____ School Year: _____

Medication: _____

Dosage: _____ Route: _____ Time(s) at School: _____

Purpose & Instructions: _____

Special Circumstances / Follow-Up / Discontinue Date (if applicable): _____

- ☐ This medication is an asthma, respiratory, anaphylaxis, diabetes, or other emergency medication
- ☐ Backup medication provided to school (if required)

AUTHORIZATION (Parent/Guardian – Initial All That Apply)

_____ Self-Carry & Self-Administration of Medication

I request that my child be permitted to possess and self-administer the medication listed above at school and during school-sponsored activities. I understand competency must be demonstrated to licensed health personnel working under the auspices of the district.

_____ Participation in Special Health Services (if applicable)

I authorize my child to participate in the planning, management, and delivery of prescribed health services after demonstration of proficiency to licensed school health personnel.

PARENT/GUARDIAN CONSENT & ACKNOWLEDGEMENTS

- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for improper use of medication or for supervising, monitoring, or not interfering with self-administration.
- I agree to coordinate with school personnel and notify them of any changes in the student's condition or medication.
- I agree to provide safe delivery of medication/equipment to and from school and to retrieve remaining medication or equipment at the end of the school year or upon expiration.
- I understand that misuse of self-administration privileges may result in revocation after parent notification, and disciplinary actions may be imposed.
- I consent to sharing this information with appropriate school personnel in accordance with FERPA and applicable laws.
- I understand students are responsible for maintaining their self-administration record when required.

PARENT / GUARDIAN SIGNATURE

Name: _____

Signature: _____ Date: ____ / ____ / ____

Phone: _____

PRESCRIBER AUTHORIZATION

Prescriber Name & Credentials: _____

Signature: _____ Date: ____ / ____ / ____

Phone: _____