



Physician Authorization to Self-Carry Emergency Medication at School

I have diagnosed _____

(Student's Name)

with _____

(Name of Chronic Disease)

for which emergency medication _____ may be needed

(Name of Medication)

while at school or during school sponsored activities.

I have instructed this patient on how to safely and appropriately use this medication, and I believe they are capable of following these instructions. I also believe this patient should carry the medication and use it responsibly, in accordance with my orders and instructions.

Physician Name (*printed*): _____

Physician Signature: _____ **Date:** _____