

ACADEMY OF THE
HOLY NAMES

School policy permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse/principal approvals.

Name of Student _____ Date _____ D.O.B. _____

Address	Grade

Condition for which the medication is administered

Name of medication, dose and method administered

Time or indication for administration

Side effects to be noted/reported

Other recommendations _____

Duration (dates) of administration: From _____ to _____ (limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician Signature	Print Name	Telephone	Date
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PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to: ☐ carry ☐ self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

Parent Signature _____ Date _____

Student Signature
Date

Parent Telephone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

School Nurse/Principal Signature _____ Date _____