Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

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 _____

Is this a controlled drug _____ Yes _____No

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

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.