Self-Carry and Administration Form for Emergency Medications

Must be accompanied by a Prescription Medication Authorization Form

Student's Name:_____**Grade:**_____

Parent/Guardian:_____**Phone #:**_____

Health Care Provider:_____**Phone #**:_____

Medication:_____Dose and Time/Frequency:_____

Medication:_____Dose and Time/Frequency:_____

Medication:_____Dose and Time/Frequency:_____

Medication:_____Dose and Time/Frequency:_____

The student's name must appear on the medications and/or devices. This form is valid for one year from the date of signing.

Parent Authorization

I hereby release Carolina Day School and their agents and employees from all liability that may result from my child taking the prescribed medication(s). Please check all that apply.

I agree to allow my child to bear the responsibility of carrying the medications listed above.

I agree to allow my child to bear the responsibility of self-administering the medications listed above.

My child is able to demonstrate proper use and care of the medications listed above.

Parent/Guardian's Signature: _____**Date:**_____

Student Responsibilities

I plan to keep my inhaler/equipment, epinephrine auto-injector, or diabetes medication/equipment with me at school and off-campus school functions;

I agree to use my inhaler/equipment, epinephrine auto-injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care provider's orders.

I will notify the school staff (i.e. teacher, nurse) if I am having more difficulty than usual with my health condition.

I will not allow any other person to use my medication or equipment.

*I will keep my inhaler/EpiPen in the following location (locker/backpack etc)*_____

Student's Signature: _____**Date:**_____

Student's Signature: _____ **Date:**_____