AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

A. <u>To be completed by the licensed healthcare provider:</u>

Student's name: ______________________ has been instructed in the proper use of

the following medication (s): ____

____

IN MY PROFESSIONAL OPINION, THIS STUDENT SHOULD BE ALLOWED TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION (S)

___________________________________ ______________________

Licensed Health Care Provider's Signature **Date**

B. <u>To be completed by the parent or guardian:</u>

I request that my child ___________________________________ be permitted to carry the above prescribed medication (s) on his/her person or to keep the above prescribed medication(s) in her/her locker or PE locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. The student understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

___________________________________ ______________________

Parent/Guardian Signature **Date**

The licensed health care providers statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

___________________________________ ______________________

School Nurse Signature **Date**

NOTE: this form must be completed *<u>in addition</u>* to the parent and prescriber's authorization form for administration of medication in school.

Date form received in health office ________________________