Parent and Prescriber's Authorization to Administer Medication in School

To Be Completed by Parent

Student Name: _____ **DOB**: _____

I request that my child receive the medication listed on this order as prescribed by our licensed healthcare provider *unless* indicated as a self-carry by the physician. If ordered as a self-carry, I agree that my child can use their medication effectively and may carry and use this medication independently with no supervision by school staff (intervention and support is needed only during an emergency). The medication will be delivered by me in the properly labeled original container. The school nurse may contact the provider as needed.

Parent/Guardian Name (please print) _____

_____ _____
Parent/Guardian Signature Date

To Be Completed by Health Care Provider – Valid for 1 Year

I request that my patient _____ receive the following medication:

Medication: _____

Dosage: _____ **Time to be taken**: _____ **Route:** _____

Possible side effects: _____

Diagnosis: _____

Independent Carry and Use Attestation
I attest that this student has been instructed and demonstrated to me that they can self-administer the emergency medication listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff
____YES, I attest to this statement. Student may self-carry medication
____NO, I do not attest to this statement. Please keep medication in the health office

Healthcare Provider/Title (please print) _____

Signature _____ **Date:** _____

Stamp: