

EMERGENCY MEDICATION

AUTHORIZATIONS FOR SCHOOL ADMINISTRATION

Such emergency medications include **Epinephrine** (for severe allergies); **Inhalers** (for asthma); and, **Insulin/Glucagon** (for diabetes).

A **HEALTH CARE PROVIDER ORDER** and **PARENT/GUARDIAN PERMISSION** is needed in order for a student to self-carry and use medications that require rapid administration.

The following information should be completed by the student's medical provider and parent/guardian:

TO BE COMPLETED BY HEALTH CARE PROVIDER:

I request that my patient, as listed below, receive the following medication(s):

NAME: _____ DOB: ____/____/____ GRADE: _____

MEDICATION(S)	DOSAGE ROUTE	FREQUENCY TIME	REASON FOR MEDICATION	DURATION OF TREATMENT

Possible Side Effects/Adverse Reactions: _____

***() I attest that this student has been instructed and has demonstrated to me that he/she can self-administer the medication(s) listed above safely and effectively; and, they 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, either on his/her person or to keep in his/her locker.**

() Yes, student may carry and self-administer medication

() No, I do not attest to the above-mentioned statement. Student's medication should be kept in health office.

Name of Health Care Provider and Title (please print): _____

Health Care Provider's Signature: _____ Date: ____/____/____

Address: _____ Phone: _____

TO BE COMPLETED BY THE PARENT OR GUARDIAN: I request that my child _____ receive the medication(s) as prescribed above by our licensed health care provider.

***() I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.**

Parent/Guardian Signature: _____ Date: ____/____/____

Address: _____ Phone: _____