Red Oak I.S.D.

Authorization for Self-Carry/Administration of Medication

(At school and after-school activities)

TO BE COMPLETED AND SIGNED BY THE PHYSICIAN

Student Name:_____ DOB:_____

School:_____ Grade:_____

Physical condition/s for which treatment is to be given:_____

Medication & Time:_____

Self Administration of: _____inhaler _____EpiPen

_____Yes: Child received training in the proper use of the inhaler and/or EpiPen.

_____Yes: Child demonstrated the proper technique while using the inhaler and/or EpiPen.

_____Yes: Recognizes proper and prescribed timing for medication.

_____Yes: Does not share medication with others.

_____Yes: Agrees to come to the clinic after using inhaler/emergency medication for evaluation.

_____Yes: I request that the child carry and self-administer the above named medication during school hours and at school activities.

PRECAUTIONS: (possible untoward reactions & recommended interventions):_____

☐ The parent/legal guardian will supply additional medication/inhaler or EpiPen to be kept in the school clinic in case the child fails to have the medication/inhaler/EpiPen with him/her.

☐ In my opinion, this student shows capability to carry and self-administer the above medication.

The health services staff will accept the parent request and physician statement. They 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 if there is a safety risk. The health services staff will contact the parent as soon as possible in this event. The school and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student outside the supervision of the health services staff.

Physician Signature:_____ Date:_____

Physician Printed Name:_____ Physician Phone Number:_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Phone Number:_____

Student Signature:_____ Date:_____