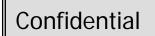


## Authorization to Carry and/or **Self-Administer Physician Prescribed Medication**



a caretaker relative educationa	e prescribing physician/provider and a al authorization affidavit, or legal gua				
Student's Name: Sex: (Please check) Fe	<del></del>	School	Grade		
Sex: (Please check) Fe Birth Date://	male Male	City: School Year:	(renew each year)		
Physician's Authorization: The above named student has	my authorization to carry and self a	dminister the following m	edication:		
Medication: (1)	Dosage: (1)				
(2)		Dosage: (2)			
Medication(s) to be used unde  I confirm that this student has medication on his own without	r the following conditions: been instructed in the proper use of school personnel supervision. I have apply laxis episodes and for medication	this medication and is ale provided a written treat	ole to self-administer this ment plan for managing		
	Physician's Phone Number	Date			
Signature of Physician		provider procesibes "back	un" modication to be kent at		
Backup Medication – The law <sub>l</sub>	provides that if a child's health care page a predetermined location, known to t	•	•		

student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self medicate as listed above, if needed. If he/she has used an auto-injectable epinephrine, he/she understands the need to alert an adult that emergency medical personnel need to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an

I also acknowledge that the school district may not incur liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional

I agree to also work with the school in establishing a plan for use and storage of backup medication if prescribed, as above, by my child's physician. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma or anaphylaxis emergency.

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the physician may rewrite the order on his prescription pad and I, the parent/guardian, will sign the new form and assure the new order is

at is not

attached.	,	· ·			3	. 3	,		
	erstand it is my res will be disposed of		ck up any u	nused medica	ation at the	e end of the	e school year,	and the medication	on tha
Parent/G	uardian Signature	e:				Date:			