UPPER ST. CLAIR SCHOOL DISTRICT HEALTH SERVICES
AUTHORIZATION FOR POSSESSION & SELF ADMINISTRATION OF EMERGENCY MEDICATIONS

Student Name: _____ Birthdate:_____

School: _____ Grade: _____

School policy permits a responsible, trained student to carry and/or self-administer medication for asthma, or severe allergic (anaphylactic) reaction, on his/her person for immediate use in a life-threatening situation with written order of licensed prescriber, parent request, and the school nurse approval.

Licensed Prescriber Medication Order

Patient's Name: _____ Date:_____

Name of medication:_____Route and dosage:_____

Time or indication for administration:_____

This student is capable of self-administration of medication for asthma, or severe allergic (anaphylactic) reaction (e.g. inhaler, EpiPen. This student should be allowed to carry approved medications with them at school and on school sponsored trips.

Licensed Prescriber signature:_____

Licensed Prescriber name printed: _____Phone:_____

Parent/Guardian Consent

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication and be responsible for its proper storage and use. I understand that the medication must be in a pharmacy labeled container. I fully understand the directions that have been given to the school by the physician and I give my consent for the medication prescribed by the physician to be administered to my child at school or for the school to monitor the self-administration of the medication by my child. In consideration of the School District's agreement to use good faith efforts to follow the physician's instructions, I hereby release the School District and its personnel from any liability associated with the administration of this medication either by School District personnel or by my child. My child understands that they shall notify the school nurse immediately following each occurrence of self-administration of medication.

Parent/Guardian signature:_____Date:_____

The District has reviewed and accepts the parent request and physician statement. The identified student is permitted to self-administer in accordance with this form. The District reserves the right to withdraw the approval of self-administration at school if the student shows signs of irresponsible behavior or there is a safety risk. The parent/guarding will be notified immediately of any revocation of the student's ability to self-administer at school.

School Nurse Signature:_____ Date:_____

TO BE COMPLETED BY THE STUDENT:

I agree to:

_____ Follow my physicians/licensed prescriber's medication orders.

_____ Verbalize knowledge of prescribed medications proper use and side effects.

_____Be responsible and not allow anyone else to use my medication.

_____ Keep a supply of my medication with me and in a safe place.

_____Notifiy the school nurse when the medicine is given.

I understand that permission for possession and self-administration of my medication may be suspended if I am unable to maintain the criteria listed above.

Student signature_____Date_____