SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

PERMISSION TO CARRY MEDICATION ON PERSON FOR SCHOOL PURPOSES

Student_____ Grade_____ School_____

Parent/Guardian_____ Phone_____

I request that _____ be allowed to carry and self-administer his/her prescribed medication for school purposes. The student has been instructed in its proper use and informed of any possible side effects.

Name of Medication_____ Purpose_____

History of student experience with condition_____

Dosage to be taken_____ Time to be taken_____

Starting date_____ Termination date_____

Possible side effects_____

Authorized Prescriber Signature_____ Date_____

Note: If this medication is an asthma inhaler or EpiPen, it is required that one back-up inhaler/EpiPen be kept in the school medicine cabinet. It will be used if the student should come to school without the inhaler/EpiPen, or if the one carried should malfunction or be depleted during the school day.

The district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and the parent/garden shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of the medication by the pupil.

I request that my child be allowed to carry his/her own medication and self-administer as prescribed.

Parent/Guardian_____ Date_____

Principal_____ Date_____

School Nurse_____ Date_____

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THIS FORM MAY ONLY BE USED FOR LIFE-THREATENING CONDITIONS; ASTHMA INHALERS OR EPIPENS FOR SEVERE ALLERGIC REACTIONS. (This is not intended to allow students to self-administer any other medications).