AUTHORIZATION FOR SELF-CARRY/ ADMINISTRATION OF MEDICINE AT SCHOOL
FOR ASTHMA, DIABETES AND ANAPHYLAXIS

EISD permits a responsible, trained student to self-administer and/or carry medication for asthma (wheezing), severe allergic reaction (anaphylaxis) and diabetes on his/her person for immediate use in a life-threatening situation with written order from physician, request from parent and approval of school nurse.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Name of Student _____ Date_____ DOB_____

Address_____Grade_____

Condition for which the medication is administered_____

Name of medication, dose and method administered_____

Time or indication for administration_____

Side effects to be noted/reported_____

Other recommendations_____

Duration (dates) of administration: From_____ To_____ (limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

_____

Physician Signature Print Name Phone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to: ____carry ____self-administer the above ordered medication. I take responsibility for this permission and I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, name of medication, strength, dose and directions for use. I understand that the school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. In this event, I will be contacted by the nurse as soon as possible.

_____

Parent Signature Date Student Signature Date