SHENANGO AREA SCHOOL DISTRICT

AUTHORIZATION TO CARRY/SELF-ADMINSTER PRESCRIBED EMERGENCY MEDICATIONS

(STUDENT TO CARRY COPY OF THIS DOCUMENT AT ALL TIMES. ORIGINAL TO BE ON FILE IN NURSES OFFICE)

FOR PHYSICIAN USE ONLY

PHYSICIAN AUTHORIZATION

STUDENT:_____ DOB:_____ GRADE:_____

MEDICATION AND DOSE:_____

TIME OF OR CIRCUMSTANCES REQUIRING SELF-ADMINISTRATION:_____

DIAGNOSIS:_____

POSSIBLE SIDE EFFECTS/CONDITIONS TO OBSERVE:_____

_____

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

(It is preferable that additional prescription labeled medication be kept in the School Nurse's Office in the event the original is lost Or left at home)

DURATION OF AUTHORIZATION (MAXIMUM (1) SCHOOL YEAR):_____

PHYSICIAN'S SIGNATURE:_____ DATE:_____ PHONE#:_____

PRINT PHYSICIAN'S NAME:_____ ADDRESS:_____

FOR STUDENT USE

I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication ONLY according to the above instructions from my doctor. I will not share this medication under any circumstances. I will understand that, should another student use my medication, the privilege of carrying my medication with me will be taken away. I also agree to go directly to the school nurse, a teacher, coach, or an athletic trainer or principal, after using my medication in order to report its use.

STUDENT SIGNATURE:_____ DATE:_____

FOR PARENT /GUARDIAN USE

I request that my above named child be permitted to carry/self-administer the above medication as per the order of the physician. I understand that the medication must be in properly labeled pharmacy container. I understand that I, the parent/guardian, accept the responsibility should the above medication be lost, given to, or taken by a person other than the above named student. I understand Shenango Area School District has no legal responsibility to ensure that the medication is taken or when the above mentioned student administers his/her own medication and bears no responsibility for the benefits or consequences of the administration of the medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE:_____

FOR SCHOOL USE

I accept the above physician's order, student's statement, and parent/guardian request. We will permit the above named Student to carry/self administer the above prescribed medication. We reserve the right to take appropriate action, which may Include withdrawing this privilege, if the student shows signs of irresponsible behavior or if there is a safety risk.

PRINCIPAL SIGNATURE:_____ DATE:_____

CERTIFIED SCHOOL NURSE:_____ DATE:_____