Keystone Schools

Allen County Non-Public School Association

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL and AFTER SCHOOL ACTIVITIES

Name of student _____ Date of Birth _____

School _____ Grade _____

Physical condition for which treatment is to be given:_____

Name of medication, route, dose, and time: _____

_____

SELF-ADMINISTRATION OF MEDICATION

_____ student received training in the proper use of the medication and/or inhaler and/or Epi-Pen.

_____ student demonstrates the proper technique while using the inhaler and/or Epi-Pen and/or taking medication.

_____ I request that the child carry and self-administer the above named medication during school hours and at school activities.

Possible untoward reactions and recommended interventions: _____

_____

_____ T*he parent/legal guardian will supply additional medication/inhaler/Epi-Pen to be kept in the school office in case the child fails to have the medication/inhaler/Epi-Pen with him/her.*

_____ *In my opinion, this student show capability to carry and self-administer the above medication.*

_____

Name of physician Print Name Telephone Date

I request that my child, named above, be permitted to: _____ carry and _____ self-administer the above ordered medication. I take responsibility for this permission.

_____

Parent/Guardian signature Student's signature Telephone Date