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Authorization for Student to Carry Medication

Student First and Last Name _____ Date of Birth _____ Grade/Homeroom _____

The above-named student needs to carry the following prescribed emergency medication/medical supplies: _____ for anaphylaxis, asthma, diabetes, and/or seizures while on school property/school trips. The above-named student has been instructed and demonstrates understanding of the proper use of this medication. It's my professional opinion that the student be permitted to carry and self-administer this medication. I have provided the parent/legal guardian with the appropriate action plan.

Printed first and last name of prescribing physician _____ Signature of prescribing physician _____

Practice Name and Phone Number _____ Date _____

I have been instructed in the proper use of the above-named medication/medical supplies, and fully understand how and when to use it. I will always carry the above-named medication/medical supplies with me, and will not allow another student to handle or use it. I will notify the School Nurse/ teacher/coach of any complications/symptoms of my medical condition and each time I use the above-named medication while on school property/school trips.

Student first and last name _____ Signature of student _____ Date _____

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use the above-named medication/medical supplies while on school property/school trips. I accept legal responsibility should the medication/medical supplies be lost, damaged or not immediately available, or given to/taken by another person other than the above-named student. I understand if this happens, the privilege of carrying the medication/medical supplies may be revoked.

I have read the school's Parent Medical Policy and Medication Policy. I will inform the School Nurse/ designated staff of any changes/complications to my child's medical condition, as well as any changes in treatment or medication, and submit a new form to reflect the changes.

The appropriate action plan and Authorization for Medication forms must be completed by the above-named student's physician and returned to the Health Center along with this completed form. I will also provide and bring 2 sets of the medication/medical supplies to the Health Center. 1 set will carried by the above-named student and the other set will be kept in the Health Center as a backup, after being processed by the School Nurse.

I hereby release High Meadows School and its employees and officials of any legal responsibility when supervising/assisting in this medication administration, and anything related to the above-named student's possession and self-administration of the above-named medication/medical supplies.

Parent/Legal Guardian First and Last Name _____ Parent/Legal Guardian Signature _____ Date _____

Revised 12-09-2019