Emery County School District

Policy: JLCD-E2 – Authorization for Student Self-Administration of Medications

Date Adopted: 1 February 2012
Current Review / Revision: 1 February 2012

Name of Student_____ Date of Birth_____

Address_____ Home Phone_____

Parent/Guardian_____ Work Phone_____

School/Teacher_____

Name of licensed medical provider completing form: (please print)

_____

Licensed Medical Provider's Statement:

1. Name/type of medication_____

   _____Asthma Medication _____Epinephrine (auto-injector) ____Diabetes Medication

2. Medical Provider Instructions_____

   _____

   _____

3. Anticipated reactions to medication (symptoms, side effects etc)_____

   _____

   _____

I hereby verify that I am authorized to prescribe or direct the use of the medication described above and that it is medically necessary for use by the student listed on this form. I also verify that the student listed above is responsible and capable of self-administering the medication described and that the student must be in possession of the medication at all times.

_____ _____

Signature of Licensed Medical Provider Date

Parent/Guardian Request and Approval

I hereby understand and give permission for the above named student to carry and self-administer the specified medication as stated in the above instruction from the medical provider. I certify that my child is responsible for, and capable of, self-administering the medication and that my child will keep the medication in their possession at all times.

_____ _____

Signature of Parent/Guardian Date