



St. Joseph School

**AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE  
AT SCHOOL AND AFTER-SCHOOL ACTIVITIES**

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

**PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER**

Name of Student \_\_\_\_\_ Date \_\_\_\_\_ D.O.B \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

Condition for which the medication is administered \_\_\_\_\_

Name of medication, dose and method administered \_\_\_\_\_

Time or indication for administration \_\_\_\_\_

Is this a controlled drug: \_\_\_\_\_ YES \_\_\_\_\_ NO

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. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use. No more than a 45-school day supply of medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medication order.

Physician Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**SCHOOL AUTHORIZATION**

We accept the parent request and physician statement. We will permit and assist the student to be responsible but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_