HALFWAY RIII SCHOOL DISTRICT
AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL

Board of Education policy 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.

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 ____

Side effects to be noted/reported ____

Duration (dates) of administration: From ______ to _________(limit of one school year)

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 medical order.

Parent Signature: ____ Date: ________________

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: _______________

PHYSICIAN AUTHORIZATION

DUE TO THIS STUDENT'S MEDICAL CONDITION, IT IS MY OPINION THAT IT WOULD BE BENEFICIAL FOR HIM/HER TO CARRY THE ABOVE MENTIONED MEDICATON(S). THIS STUDENT DEMONSTRATES CAPABILITY TO CARRY AND SELF ADMINISTER THE ABOVE MENTIONED MEDICATION(S).

Physician's Name:____
Address: ____________________________________ Phone: _______________________________
Physician's Signature: _______________________________________ Date: _________________