

**HALFWAY R-III SCHOOL DISTRICT  
AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL**

Policy permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylaxis) reaction, or diabetes management, as directed by prescribing physician or in a life-threatening situation, with written order/consent of physician and parent/guardian request and consent.

Name of Student \_\_\_\_\_ dob \_\_\_\_\_ grade \_\_\_\_\_

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

Name of medication \_\_\_\_\_

Dose \_\_\_\_\_ Method of Administration \_\_\_\_\_

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, and give permission for, my child/student, named above, be permitted to:  
\_\_\_\_\_ carry \_\_\_\_\_ self-administer the above prescribed medication. I take responsibility for this permission.

I understand that the medication must be in the original pharmacy container, labeled with the child/student's name, prescribing healthcare provider, medication, strength and dose of medication, and directions for use.

I understand and have instructed my child/student that under no circumstances will the medication(s) be given or shared with another student. Should such a situation occur, I understand the privilege to carry medication(s) will be revoked and I agree to transport the medication(s) myself.

I understand that the Halfway R-III School District and its employees may disclose information provided to administrators, nurses, teachers, and other district employees or agents as may be necessary to protect the health of my child/student and to establish that the student has been authorized to self-carry and/or self-administer medication. I understand that the Halfway R-III School District shall incur no liability for the disclosure of such information.

I understand that the Halfway R-III School District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration or transporting of medications by my child/student, absent any negligence by the Halfway R-III School District, its employees or its agents. I shall indemnify and hold harmless the Halfway R-III School District and its employees or agents against any claims arising out of the self-administration or transportation of medication by my child/student.

Parent Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIAN AUTHORIZATION**

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

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_