CENTRAL CITY COMMUNITY SCHOOL DISTRICT
AUTHORIZATION FOR SELF-CARRY ADMINISTRATION OF MEDICINE
AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

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

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

NAME OF STUDENT:_____ DATE:_____ DOB:_____

Condition for which the medication is administered_____

Name of medication, dose, and method administered_____

Time of 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 THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Provider Signature Print Name Telephone 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 the name of the medication, the student, and the prescribing health care provider. The date of the original prescription, the strength and dose of the medication, and the directions for use will be included. No more than a 45 school day supply of the 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 Student Signature Date

Parent/Guardian Telephone Number(s)

I accept the parent request and physician statement. I 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. I will contact the parent as soon as possible in this event.

School Nurse Signature Date