AUTHORIZATION FOR SELF-CARRY / ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER SCHOOL ACTIVITIES
SUGAR MAPLE NATURE SCHOOL
PHYSICIAN / PRESCRIBING HEALTH CARE PROVIDER INFORMATION

Date: _____

Student: _____ Date of Birth: _____ Grade: _____

Medication Name: _____

Dose: _____ Method of Administration: _____

Time / Frequency: _____

Duration (dates) of Administration: from _____ to _____ (limit of one school year)

Diagnosis: _____

Precautions, Interventions, Comments: _____

_____

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION

_____ _____

Physician Signature Print Name

_____

Address: City, State, ZIP

PARENT / GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and 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 student, prescribing health care provider and medication; date of original prescription; strength and dose of medication; and directions of use. 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 Student 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

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