**(SCHOOL NAME)**

**Self-Carry Medications at School/School Sponsored Events**

**Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This section must be completed by a PHYSICIAN, CNP, or PA with PRESCRIBING AUTHORITY for medication that will need to be self-carried by your student at any time during the school day or at school sponsored events.  Medications that are permitted to be self-carried at school include Insulin Pumps, Inhalers and EPIPens, ONLY.**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time(s) medication is to be taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Certifies that:**

       1.   This student has demonstrated and understands the proper use of this medication.

       2.   This student is approved to self-carry the medication listed above on this form.

       3.   I have written a prescription for this student for this specific medication.

       4.   I have completed and signed a “Care Plan” for this student, if applicable.

**Print Prescribing Healthcare Provider’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Health Care provider with Prescriptive Authority                                                  Date**

**Student agrees to the following:**

1. I plan to keep my medication with me at school rather than in the school health office.
2. I agree to use my medication in a responsible manner and in accordance with my physician’s orders.
3. I will notify a school staff member if I have used an EPIpen and/or Inhaler.
4. I will notify a school staff member if I am experiencing symptoms of my condition and may need assistance.
5. I will not allow any other person to use my medication.

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian agrees to the following:**

1. I hereby give my permission for my student to self-carry and be solely responsible for self-administering the medication listed on this form.
2. I agree to ensure that my student self-carries his/her medication in **an original pharmacy labeled container with name, name of medication, time medication is to be given, dosage, date and licensed health care provider’s name.**  **I will ensure that his/her medication is not expired.**
3. I agree to provide a **backup medication** to be kept at the school for emergencies if my student has a life-threatening allergy that could require an EPIPen or if my student has Asthma that could require the use of an inhaler.
4. I will review the status of my child’s condition with him/her on a regular basis.
5. I will ensure that my child brings his/her medication to school every day.
6. I release school from any responsibility for side effects or other medical consequences that occur as a result of my student taking this medication.

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**