SOUTHWEST ALLEN COUNTY SCHOOLS
FORT WAYNE, INDIANA

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

Name of Student: _____ D.O.B._____

School: _____ Grade:_____

A. To Be Completed By Doctor

Acute or chronic disease or medical condition for which emergency medication has been prescribed:

_____

Treatment required, including the names of all emergency medications: _____

_____

Time for the self-administration of the emergency medication: _____

Possible Adverse Reactions and Recommended Interventions: _____

_____

Student has received training in the proper use of the medication (ie: insulin, inhaler, or EpiPen®).
AND
Student demonstrates the proper technique when taking the medication.
AND
The nature of the disease or medical condition requires emergency administration of the medication.
AND
I request that the student possess and self-administer the above named medication during school hours and at school activities.

In my opinion, this student shows capability to possess and self-administer the above medication.

_____

Physician's Signature Print Name Telephone Date

B. To Be Completed By Parent/Legal Guardian

I request that my student, named above, be permitted to possess and administer the above ordered medication. I take responsibility for this permission.

_____

Parent's/Legal Guardian's Signature Date