ST. JANE FRANCES de CHANTAL SCHOOL
AUTHORIZATION TO CARRY/SELF-ADMINISTER PRESCRIBED MEDICATION
(Original to be on file in School Nurse's Office)

FOR PHYSICIAN USE ONLY
PHYSICIAN AUTHORIZATION

Student:________________________________DOB:________________Grade_________

Medication and dose:____

Time of or circumstances requiring self-administration: ________________________________

Diagnosis: ____

Possible side effects/conditions to observe: ____

IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE NAMED MEDICATION.
(It is preferable that additional prescription labeled medication be kept in the School Nurse's Office in case the first is left at home or lost)

Duration of authorization [maximum one (1) school year]: ______________________________

Physician's signature: ________________________________ Date: ___________________

Printed physician's name: _____________________________ Phone: ________________

Address: ____

FOR STUDENT USE
I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication only according to the above instructions from my doctor. I will not share this medication under any circumstances. I understand that, should another student use my medication, the privilege of carrying my medication with me may be taken away. I will immediately report lost or missing medication. I also agree to come directly to the school nurse, a teacher, a coach, an athletic trainer or a principal after using my medication in order to report its use.

Student signature: ____Date: ______________________

FOR PARENT/GUARDIAN USE
I request that my child (named above) be permitted to carry/self-administer the above medication as per the order of the physician. I understand that the medication must be in a properly labeled pharmacy container. I understand that I, the parent/guardian, accept the legal responsibility should the above medication be lost, given to, or taken by a person other than the above-named student. I hereby waive any and all claims arising out of the above named student's self-administration of medication and release all individual employees of the School District from liability arising out of my son/daughter's self administration of medication in school. I understand that neither St. Jane Frances de Chantal School nor its employees have legal responsibility to ensure that the medication is taken or when the above-named student administers his or her own medication and bears no responsibility for the benefits or consequences of the administration of the medication.

Parent/Guardian signature(s): ____________________________________Date: ______________________

FOR SCHOOL USE
We accept the above physician's order, student's statement, and parent/guardian request. We will permit the above-named student to carry/self-administer the prescribed medication. We reserve the right to take appropriate action, which may include withdrawing this privilege, if the student shows signs of irresponsible behavior or if there is a safety risk.

School Nurse: ____Date: ____________________