AUTHORIZATION FOR SELF-CARRY MEDICATIONS

Student's Name: ______________________________________ Grade: _________________

Medication: ____

Diagnosis: ___Asthma, ___Diabetes, ____Allergies ____Seizures

*see medication form for Rx #, dosage, and route

Parent/Guardian: I give consent to allow my child to self-carry and, when applicable, to self-administer the above medication at school. I understand that my child and I assume any and all responsibility for the proper use and safekeeping of this medicine.

I __will/ __will not provide backup medication to be kept at school.

Parent Signature/Date ____

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when medication is used.

Signature/Date ____

School Medical Aide: I have reviewed this request and agree that this student should be capable of safely self-carrying and, when applicable, self-administering this medication.

School Medical Aide Signature/Date ____

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