

Authorization for Student to Carry and Independently Self-Administer Emergency Medication

Student Name: _____

To be completed by PHYSICIAN:

The student must have the medication(s) listed on the reverse of this form during the school day or at school-sponsored events. The student has been instructed in the treatment plan, self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer the medications for asthma and/or anaphylaxis. **Adult supervision is not required.** The student has been instructed in the treatment plan, self-administration for the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

Asthma Allergy Other: _____

Printed Physician's Name: _____

Physician's Signature: _____ Date: _____

To be completed by PARENT:

I request and give permission for my child to carry and self-administer the medication listed on the reverse of this form during the school day, at school-sponsored activities or while in transit or from school. I have observed my child demonstrate the necessary skill to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

I understand that:

- If required by the care plan, I am obligated to and will provide the school back-up medication (in addition to what student will carry) to be kept at school.
- If my child participates in Raleigh Charter High School before/after-school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

For Epi-Pen only:

In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, I specifically authorize a trained school staff member to administer the Epi-Pen and call 911.

Parent/Guardian Signature: _____ Date: _____

To be completed by STUDENT:

- I plan to keep my medication and equipment with me at school
- I will use only as prescribed by my doctor.
- I will not allow any other person to use my medication.
- I will notify a school staff member if I self-administer my medication, or if I am having more difficulty than usual with my health condition.

Student Signature: _____ Date: _____