

Philomath School District 17J
Authorization to Self Administer Medications

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

Board of Education policy permits a responsible, trained student to carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

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

Address _____ Grade _____

Condition for which the medication is administered _____

Name of medication, dose and method administered _____

Time or indication for administration _____

Side effects to be noted/reported _____

Other recommendations _____

Duration (dates) of administration: From _____ to _____ (limit of one school year)

**IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE
ABOVE MEDICATION.**

Physician Signature

Print Name

Telephone

Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

Parent Signature

Date

Student Signature

Date

Parent Telephone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

School Nurse Signature

Date

Principal Signature

Date