PERMISSION TO SELF-CARRY / SELF-ADMINISTER EMERGENCY MEDICATION OR MEDICAL DEVICE

STUDENT'S NAME:	
DATE OF BIRTH:	GRADE/TEACHER:
PHYSICIAN NAME:	
PHYSICIAN PHONE NUMBER:	
NAME OF MEDICATION OR MEDICAL DEVICE:	
ROUTE, DOSE, TIME OF MEDICATION:	

TO BE COMPLETED BY PHYSICIAN: The above-named student has been instructed AND has demonstrated the proper use of_____. I request that he/she be permitted to carry this at school and school sponsored activities. He/She understands the purpose, appropriate method, and frequency of use. I understand that if the student does not comply with school policy that the student's self-carry privilege will be revoked.

PHYSICIAN MUST PROVIDE A COMPLETED HEALTH PLAN YEARLY.

Physician Signature:	Date:
Physician Printed Name:	

TO BE COMPLETED BY PARENT/GUARDIAN: The above-named student has my permission to self-carry and administer the above-listed medication or medical device as ordered by his/her physician. I understand that it is my responsibility to furnish the medication or device. I release the school of any responsibility of safeguarding the student medication or device. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication, lack of administration, or misuse of medication or device and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication or medical device. I understand that if the student does not comply with school policy that the student's self-carry privilege will be revoked and the student could be subjected to school disciplinary actions.

Parent Signature:	Date:
Parent Printed Name:	

TO BE COMPLETED BY STUDENT: I know the signs and symptoms of my chronic health condition and know when I need to use my medication or device. My physician has instructed me AND I have demonstrated the proper use of my medication or device and I will use it as prescribed to me by my physician. I understand that I am to self-carry my medication or device on me at all times while at school and school related activities. I understand that I am not to give my medication or use my medical device on other students. I understand that if I do not comply with school policy that my self-carry privilege will be revoked and I could be subjected to school disciplinary actions.

Student Signature:	Date:
Student Printed Name:	

TO BE COMPLETED BY SCHOOL NURSE: The student has demonstrated proper knowledge and use of medication or device according to physician order. Student will periodically be monitored and educated to ensure student maintains skills to self-administer and carry.

_____ _____

School Nurse Signature Date