

Alachua County Public Schools  
Health Services Department  
**Self-Carry / Administration of Medication Authorization  
for Inhaler, EpiPen, Insulin and Pancreatic Enzymes**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

School Name: \_\_\_\_\_

**The following section is to be completed by the parent or legal guardian:**

List child's health conditions and allergies: \_\_\_\_\_  
\_\_\_\_\_

I give permission for my child, named above, to self-administer the following medication:

Name of medicine: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Amount to be given: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_

Prescribing doctor's name: \_\_\_\_\_

Illness or condition prescribed for: \_\_\_\_\_

Dates medicine are to be given: beginning on date: \_\_\_\_\_ ending on date: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

**I understand that, for safety reasons, it is important for the school to know what medication(s) my child is taking and if any changes in the prescription occur the school nurse will be notified.**

Parent/Guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We accept the parent request 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

\_\_\_\_\_  
Date