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