ACADEMY OF THE HOLY NAMES
SCHOOL HEALTH SERVICES
AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF EPIPEN, INHALER OR DIABETES MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

School 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/ 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_____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/Principal Signature Date