

Grand Prairie Independent School District Health Services  
**Physician/Parent Authorization for Self-Administration of Emergency Medication While on School Property or at a School-Related Activity**  
(This form is to be renewed at the beginning of each school year.)

**STUDENT** \_\_\_\_\_ **SCHOOL** \_\_\_\_\_ **GRADE** \_\_\_\_\_

I, the parent/guardian of \_\_\_\_\_, request that he/she be allowed to carry and self-administer his/her prescribed inhaler or anaphylaxis medication and be responsible for its use as needed. I understand that my child must carry the medication on their person at all times. I understand that I as the parent/guardian accept legal responsibility should the medication be lost or given/taken by a person other than the student for whom it was prescribed. If this should happen, the privilege of carrying the medication may be revoked. It is my responsibility to notify the school immediately if my child's health changes. I will provide the most current documentation to support my child's possession and self-administration of this medication on at least an annual basis. I understand that Grand Prairie ISD has no legal responsibility when the above named student administers his/her own medication. I understand that the campus nurse will be notified immediately if the anaphylactic medication is administered, and emergency medical services will be obtained.

The anaphylactic medication and inhaler must have a current prescription label indicating that this medication has been prescribed for your child. My student must be able to demonstrate to the physician, parent, and school nurse the skill level necessary to self-administer this medication in compliance with the prescription or written instructions. *(It is recommended that additional medication be kept in the school clinic in the event that the student forgets his/her medication)*

I give permission for the school nurse to communicate with the student's teachers about the student's health condition and the action of the medication. I give permission for the school nurse to consult with my child's physician regarding any questions that arise with regard to this prescribed medication, or medical condition being treated by this medication.

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**Physician's Request for Self-Administration of Emergency Medication While on School Property or a School-Related Activity**

The school district is hereby authorized to allow the above-named student to carry this prescribed medication on his/her person at all times.

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Frequency/time or circumstance under which the medicine may be administered: \_\_\_\_\_

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Student should go to the clinic if inhaler is needed more than \_\_\_\_\_ time/s during one school day.

Period of time for which the medicine is prescribed: \_\_\_\_\_

Is this student capable of self-administering the prescribed medication? Yes \_\_\_ No \_\_\_

Can this be safely self-administered in the school setting? Yes \_\_\_ No \_\_\_

Has the student been trained in the self-administration of the prescribed medication? Yes \_\_\_ No \_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: (print or type) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The physician's statement must be kept on file in the office of the school nurse or the principal of the campus the student attends.