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.

I agree that the anaphylactic medication and inhaler must have a current prescription label indicating that this medication has been prescribed for my child. My student must be able to demonstrate to the physician and parent 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.

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:_______________________

Is this student capable of self-administering the prescribed medication? Yes_____No_____

Has the student been trained in the self-administration of the prescribed medication? Yes____No___

Student should go to the clinic if inhaler is needed more than______________time/s during one school day.

Student will notify school nurse or other school staff if epinephrine self-administered.

Physician's Signature:____________________________________Date:________________________

Physician's Name: ____

(print)

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 of the campus the student attends.