**Union County School System**

# STUDENT AUTHORIZATION TO POSSESS AND ADMINISTER A PRESCRIPTION INHALER, EPI-PEN, GLUCAGON, INSULIN, OR OTHER APPROVED MEDICATION*

## Section A. To Be Completed By A Licensed Physician

_____ needs to carry the following prescription asthma medication,
Student's Printed Name
epinephrine auto injector, diabetic medication and/or prescription medication with him/her.

Medication: _____ Dosage: _____

Amount: _____ Time Schedule: _____

Method of Administration: _____

The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

_____ _____
**Physician's Signature & Stamp** **Date**

* Other Approved Medication shall be defined as prescribed medication used for emergency purposes and/or medication approved by the school nurse in collaboration with the student's health care provider.

It is highly recommended that each student keep a second prescription inhaler, epi-pen, additional insulin or other prescribed medication in the school clinic in case of emergency and in the event the first is lost or left at home.

## Section B. To Be Completed By School's Current Parent of Record

I hereby request that the above named student be permitted to possess and use the above prescribed medication at school, at a school sponsored activity, while under the supervision of school personnel or while in before-school or after-school care on school operated property.

- I accept legal responsibility should the medication be lost, not immediately available, given, or taken by a person other than the above named student, or used in an improper manner.
- I understand that if this should happen, the student may be in violation of the Student Code of Conduct and may be subject to disciplinary action, including but not limited to, altering the privilege of possessing the medication.
- I release Union County School System and its employees and agents of any legal responsibility when the above named student administers his/her own medication and if he/she should suffer an adverse reaction as a result.
- Completion of this form authorizes the school nurse or principal's designee to discuss this medication order/request/administration with the prescribing provider if indicated.

_____ _____
**Parent of Record's Signature** **Date**

## Section C. To Be Completed By Student

- I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered.
- I will not allow another student to use my medication under any circumstances.
- I understand that if I misuse or abuse the medication, or use it in a manner other than as prescribed, or in a manner that endangers the safety of other students, that I may be in violation of the Student Code of Conduct, and may be subject to disciplinary action, including but not limited to, altering the privilege of possessing my medication.
- I also accept the responsibility for notifying the school nurse or principal's designee each time I use/take my medication.

_____ _____
**Student's Signature** **Date**

*This form shall be submitted each school year and shall be updated if the medication, dosage, frequency of administration, or reason for administration changes.*