Athlos Academy
JEFFERSON PARISH

Self-Administration of Medication

Student:

____

First Name ***Last Name*** ***Grade*** ***Teacher***

A physician may recommend that a student with a chronic health diagnosis, such as asthma, severe allergies, or diabetes assume responsibility for his/her own medication in case of emergency. These students may self-administer medication, such as through the use of a metered-dose inhaler or epi-pen, provided that they may require urgent relief and the conditions set forth in state law have been met.

*If your child requires medication at school, it must be in the original prescription container with the current date and child's name. An "Authorization to Administer Medication" form must be on file.

Indicate which medications this student requires:

Inhaler **Epi-pen** **Insulin** **Other:** ____

***Physician's consent may, at the discretion of school administration/nurse, be required if "other" is checked

PARENTAL CONSENT

I(we), the undersigned, the parent(s)/guardian(s) of the above named student, request our child be permitted to administer his/her own medication. I(we) will:

1. Provide all medication, supplies, and equipment.
2. Notify the school if there is a change in the pupil's health status or attending physician.
3. Notify the school and provide a new consent for any changes in the doctor's orders.
4. **Acknowledge that my(our) student carries and administers his/her own medication, and that it must be on his/her person in order to attend a field trip.**

I(we) authorize the school to communicate with the Authorized Health Care provider when necessary in regard to this specific medication and medical condition.

Parent/Guardian Signature: ____ **Date:** _________________
Parent/Guardian Signature: ____ **Date:** _________________

PHYSICIAN'S CONSENT

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel, under the training and supervision provided by the school. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

1. I have instructed ______________________________ in the proper use of his/her medications. It is my professional opinion that he/she **should be allowed** to carry and self-administer the medication.

2. It is my professional opinion that _________________________ **should not** carry or self-administer his/her medication.

Physician's Signature: ____ **Date:** ____________________

Executive Director's Signature: ____ Date: _______________