Authorization for Student to Carry Approved Medication

***HARALSON COUNTY SCHOOL DISTRICT RESERVES THE RIGHT TO SEEK EMERGENCY MEDICAL TREATMENT FOR ANY STUDENT WHEN DEEMED NECESSARY AND APPROPRIATE. THE PARENT/GUARDIAN IS RESPONSIBLE FOR ALL EXPENSES.**

_____ needs to carry the following prescription labeled inhaler, EpiPen, insulin, and/or other approved medication with him/her. (**Other approved medication** shall be defined as **PRESCRIBED** medication used for **EMERGENCY** purposes and/or medication approved by Student Health Services in collaboration with the physician and/or health care provider.) The above named student has been instructed in the proper use of the medication and fully understands how to administer the medication. **It is preferable that a 2nd prescription inhaler, EpiPen, additional insulin or other prescribed medications be kept in the shool clinic in case the 1st is lost or left at home**

Is an Asthma Action Plan needed for this student? Yes or No

Medication Name and Dosage: _____

Administration Instructions/Other Special Instructions: _____

_____

Possible Side Effects: _____

_____

Physician's Signature: _____ **Date**: _____

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is to be administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept the responsibility of notifying the School Nurse and/or a School Administrator each time I take or use my medication.

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

I hereby request that the above named student, over whom I have legal guardianship be allowed to carry and use this prescribed medication at school. Furthermore

- I accept legal responsibility should the medication be lost, given, or taken by a person other than the above named student.
- I understand that if this should happen, the privilege of carrying this medication may be altered.
- I release Haralson County School District and its employees of any legal responsibility when the above named student administers his/her own medication.
- I will notify the School Nurse if any medication changes are made.

Parent/Guardian Signature:_____**Date**: _____

*This form is effective only for the school year in which such authorization is granted but subsequent authorization may be granted in any school year in accordance with this policy.

Emergency Contacts:

Name: _____**Phone Number:** _____

Name: _____**Phone Number:** _____