AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

Leander ISD policy permits a responsible, trained student to carry and self-administer certain medications for immediate use in a life-threatening situation with written order of physician, parent request, and school nurse/clinic assistant and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student _____ DOB _____ School _____
Address _____ Grade _____
Condition for which the medication is administered _____
Name of medication, dose, and method administered _____
Time or indication for administration _____
Side effects to be noted/reported _____
Other recommendations _____
Duration (dates) of administration: From _____ To _____ (Limit of one school year)
IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

_____	_____	_____	_____
Physician Signature	Print Name	Telephone	Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry/self-administer the above ordered medication. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing physician and medication, dose of medication and directions for use. It must be a current prescription and medication must not be expired. I understand that this medication may not be distributed by my child to anyone else and that I may be liable if my child does distribute this medication to anyone else. I understand that my child will be held responsible for the possession and control of the medication during the time he/she is under the school's jurisdiction. I understand that LISD cannot be held liable for any misuse/abuse of the medication by my child. Therefore, I release Leander ISD from any responsibility for my child's actions with regard to the prescribed medication. Furthermore, I realize that any misuse/abuse of the medication by my child may result in disciplinary action by the Leander ISD.

_____	_____	_____	_____
Parent Signature	Date	Student Signature	Date

_____
Parent Telephone Numbers

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

_____	_____	_____	_____
Nurse/Clinic Assistant Signature	Date	Principal Signature	Date

*** EMS will be called when an Epi-pen is administered.**

White – Clinic Copy Yellow – Parent Copy