AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL & AFTER-SCHOOL ACTIVITIES
Brentwood Borough School District

Student Name: _____ Birth date: _____

School: _____ Grade: _____

School policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of licensed prescriber, parent request, school nurse and principal approvals.

Licensed Prescriber Medication Order

Patient's name: _____ Date: _____

Name of medication: _____

Route and dosage: _____

Time or indication for administration: _____

Other recommendations: _____

Duration (dates) of administration: _____ (limit of one school year)

Licensed Prescriber signature: _____

Licensed Prescriber name printed: _____ Phone: _____

Parent/Guardian Consent

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication and be responsible for its proper storage and use. I understand that the medication must be in a pharmacy labeled container.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____Phone: _____

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.

School Nurse Signature: _____ Date: _____

Principal Signature: _____ Date: _____