METROLINA REGIONAL SCHOLARS ACADEMY

AUTHORIZATION FOR SCHOLARS ACADEMY STUDENTS TO SELF-CARRY EMERGENCY MEDICATIONS

Student's Name: _____ Birth Date: _____

Medication: _____

Purpose of Medication: _____

Eligibility: Only students with asthma, diabetes and/or severe allergies who may require rescue medications (i.e. inhaler, glucagon, epinephrine).

Healthcare Provider: This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed on the Permission to Administer Student Medication Form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities.

Heathcare Provider: _____ Date: _____
Signature

Parent/Guardian: I give consent to Metrolina Regional Scholars Academy to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve Scholars Academy and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent/Guardian: _____ Date: _____
Signature

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared.

I will inform an adult when medication is used.

Student: _____ Date: _____
Signature

School Health Nurse/Executive Director: I have reviewed this request and agree that this student should be capable of safely self-carrying and, when applicable, self-administering this medication.

Nurse/Director: _____ Date: _____
Signature