NOTRE DAME SCHOOLS
EAST STROUDSBURG AREA SCHOOL DISTRICT
AUTHORIZATION TO CARRY/SELF ADMINISTER PRESCRIBED MEDICATION

(Student to carry copy of this document at all times. Original to be on file in School Nurse's Office)

FOR PHYSICIAN USE ONLY
PHYSICIAN AUTHORIZATION

Name______________________________________ Date____________________

Medication and dose____

Time of or circumstances requiring self-administration________________________

Diagnosis____

Possible side effects/conditions to observe__________________________________

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IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE-NAMED MEDICATION.

(It is preferable that additional prescription labeled medication be kept in the School Nurse's Office in case the first is left at home or lost)

Duration of authorization [maximum one (1) school year]_________________________

Physician's Signature______________________________ Date____________________

Printed Physician's Name___________________________ Phone___________________

Address____

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FOR STUDENT USE

I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication only according to the above instructions from my doctor. I will not share this medication under any circumstances. I understand that, should another student use my medication, the privilege of carrying my medication with me may be taken away. I will immediately report lost or missing medication. I also agree to come directly to the school nurse, a teacher, a coach, an athletic trainer or a principal after using my medication in order to report its use.

Student Signature__________________________________ Date____________________

FOR PARENT/GUARDIAN USE

I request that my child (named above) be permitted to carry/self-administer the above medication as per the order of the physician. I understand that the medication must be in a properly labeled pharmacy container. I understand that I, the parent/guardian, accept the legal responsibility should the above medication be lost, given to, or taken by a person other than the above-named student. I understand that the Notre Dame Schools have no legal responsibility for the benefits or consequences of the administration of the medication.

Parent/Guardian Signature(s)_________________________ Date____________________

FOR SCHOOL USE

We accept the above physician's order, student's statement, and parent/guardian request. We will permit the above-named student to carry/self-administer the prescribed medication. we reserve the right to take appropriate action, which may include withdrawing this privilege, if the student shows signs of irresponsible behavior or if there is a safety risk.

Principal____ Date____________________

School Nurse_______________________________________ Date____________________