Rev. 08/12

CUMBERLAND COUNTY SCHOOLS

EMERGENCY SELF-MEDICATION AUTHORIZATION FORM

TEACHER _____ SCHOOL _____

STUDENT _____ GRADE _____ DOB _____ AGE _____

MEDICATION _____ DOSE _____ ROUTE _____

TIME INTERVAL _____

Under which conditions should medications be administered? _____

I verify that the student has asthma or an allergy that could result in an anaphylactic reaction, or both, and that I, the health care practitioner, prescribed medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

I prescribed the asthma and/or allergy medication and I confirm that the student has been instructed in self-administration of the prescribed medication. The student has demonstrated the skill level necessary to use the asthma and/or allergy medication and any device that is necessary to treat his/her symptoms.

Physician's Signature	Phone Number	Date

I have read the **guidelines for students with emergency self-medication in their possession at school** and I judge that my child named above has sufficient maturity and knowledge to safely and correctly self-medicate.

I understand that my child must comply with the following:

- The student must keep the medication in his/her possession at all times and shall not leave it in a place accessible to other students
- The student shall not offer, nor allow any use of his/her medication by another student
- The student shall act in a responsible and discreet manner concerning his/her emergency medication

I understand that if my child has significant difficulty with his/her medication (i.e. asthma) requiring repeated use of inhaled medication; he/she shall not continue to use the medication in the place of getting appropriate medical care. I also understand that backup medication must be provided to the school within 14 calendar days of this authorization.

I further understand that the only liability that the school can assume is to comply with the terms of this protocol. I understand that the school can assume no liability for monitoring self-administration, including the frequency and dose or failure to self-medicate when necessary.

I consent for the health care practitioner to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

I have read and agree with this authorization and have provided the school backup emergency medication for my child.

Parent/Guardian Signature _____ Date _____

FOR SCHOOL NURSE USE ONLY

This student has demonstrated the skill level necessary to use emergency medication or device.

Public Health School Nurse Signature	Date

School Administrator's Signature _____ Date _____

FOR SCHOOL USE ONLY

Date Emergency Self-Medication Form Expires / /

Please be reminded form will expire one (1) year from date of Physician's signature.