Upper Darby School District
Consent to Self-carry and Self-administer

Special instructions for prescriber regarding orders for emergency medication such as epinephrine, "rescue" asthma inhalers, and medication for diabetes:

NAME OF STUDENT_____ DOB_____ GR_____

Diagnosis for which medication is prescribed: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: _____

Possible side effects/adverse reactions: _____

Start date: _____ End date: _____ (Limit of one school year)

Specific instructions regarding administration: _____

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

_____ _____ _____ _____
Licensed Provider Signature Print Name Phone # Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing licensed provider and medication, date of original prescription, strength and dose of medication, and directions for use.

_____ _____ _____ _____
Parent Signature Date Student Signature Date

The School Nurse will accept the parent request and physician statement. The School Nurse 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 if there is a safety risk. The School Nurse will contact the parent as soon as possible in this event.

_____ _____ _____
School Nurse Signature School Child Attends Date