Hillsborough County PUBLIC SCHOOLS
Excellence in Education

Authorization For Student to Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. I feel that this student has a life threatening illness and that he/she is capable of and has been instructed in the proper administration of the required medication(s) and/or procedure(s). The student has been instructed in the treatment plan, self-administration of their medications / procedures and has demonstrated the skill level necessary to manage their own care.

Telephone	*Printed Physician's Name*	*Signature*	*Date*

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication(s) and/or procedure(s), as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from schools. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, procedure equipment and supplies for their life threatening condition. Adult supervision will not be provided. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the district harmless against any injury or claims that arise as a result of the student's self-management of life threatening condition. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication(s) and/or procedure(s). We/I are aware the privilege of self-administration of medication(s)/procedure(s) can be withdrawn if abused by the student. The district reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication, supplies & equipment with me at school ☐ I will use only as prescribed by my doctor ☐ I will not allow any other person to use my medication(s) or procedure equipment ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*
Printed Registered Nurse Name	*Signature*	*Date*

Distribution: Nurse

(rev May 2014)