Student Health Services SHS-2 Form

School Year: _____

Authorization for Students to Carry a Prescription Inhaler, Epipen, Insulin, or Other Approved Medication*

See Operating Guidelines on Medication Administration

Student Name_____ **Grade** _____ **DOB** _____

(PRINT LEGIBLY)

I AGREE TO THE FOLLOWING:

- I need to carry the following prescription-labeled inhaler, Epipen, insulin, and/or approved medication _____.
  (PRINT NAME OF MEDICATION LEGIBLY)
- I have been instructed in the proper use of my labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription or medication, the privilege of carrying my medication may be reassessed and/or revoked. I also accept the responsibility for notifying the Clinic Assistant or School Cluster/Special Education Nurse each time I take my medication.

_____ _____

Student Signature **Date**

(Student Health Services strongly encourages each student to keep a second prescription inhaler, Epipen, additional Insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this medication at school:

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container;
- I release Fulton County Schools System and its employees of any legal responsibility when supervising or assisting in this medication administration or when the above named student administers his/her own medication;
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing provider if indicated or needed.

_____ _____

Parent/Guardian Signature **Date**

Healthcare Provider and Parent/Guardian: ***Please turn form over for additional information and instructions.***

To be Completed by the Physician/Healthcare Provider

(For Prescription Medication ONLY)

MEDICATION NAME:	PRESCRIBED DOSAGE:
POSSIBLE SIDE EFFECTS:	
ADMINISTRATION AND OTHER SPECIAL INSTRUCTIONS:	
CONDITION OR ILLNESS REQUIRING MEDICATION:	

_____ _____

Physician's Signature **Date**

Physician's Name (please PRINT legibly): _____

Office/Contact Number: _____ **Fax:** _____

To Be Completed by Parent/Guardian

Emergency Contact Names and Numbers:

Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Other Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Other Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

***Other Approved Medication – shall be defined as prescribed medication used for emergency purposes and/or medication approved by Student Health Services in collaboration with the student's parent/guardian or healthcare provider.**

Fulton County Schools System reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

This form is effective only for this school year and includes all school sponsored Fulton County Schools System activities and summer school.

_____ _____

Cluster/Special Education Nurse Signature **Date Received**

Revised December 2010