EMERGENCY SELF-MEDICATION AUTHORIZATION FORM

Prescriber Authorization

Student Name: _____ Grade/Section: _____ DOB: _____

School: _____ Teacher: _____ Age: _____

Medication: _____

Dose: _____ Route: _____

Under which conditions should medications be administered?_____

_____

◉ Yes, I have provided an Allergy/Asthma Action Plan ○ No, I have not provided an Allergy/Asthma Action Plan

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

Parent Authorization

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 request that school health staff allow my child to self-carry with the intention to self-administer the medication described above by my child's primary prescriber. I agree to notify the school nurse or school health staff and provide a new self-medication authorization form when there is a change in my child's medication, health status, or authorized healthcare provider.

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____

School Nurse Authorization

An evaluation of the student's ability to self-administer their asthma or anaphylaxis medication was conducted by an authorized Valor personnel.
Self-Administration Evaluation Date: _____/_____/_____

◉ This student has demonstrated the skill level necessary to use emergency medication or device.
○ This student has NOT demonstrated the skill level necessary to use emergency medication or device. Explanation: _____

School Nurse Signature: _____ Date: _____

School Administrator's Signature: _____ Date: _____