Authorization for Student to Carry and Independently Self-Administer Emergency Medication

Student Name:_____

To be completed by PHYSICIAN:

The student must have the medication(s) listed on the reverse of this form during the school day or at school-sponsored events. The student has been instructed in the treatment plan, self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer the medications for asthma and/or anaphylaxis. **Adult supervision is not required.** The student has been instructed in the treatment plan, self-administration for the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

[ ] Asthma [ ] Allergy [ ] Other:_____

Printed Physician's Name:_____

Physician's Signature:_____Date:_____

To be completed by PARENT:

I request and give permission for my child to carry and self-administer the medication listed on the reverse of this form during the school day, at school-sponsored activities or while in transit or or from school. I have observed my child demonstrate the necessary skill to implement the care plan prescribed by his/her health care provider. Adult supervision will not be required.

I understand that:

- If required by the care plan, I am obligated to and will provide the school back-up medication (in addition to what student will carry) to be kept at school.
- If my child participates in Raleigh Charter High School before/after-school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

For Epi-Pen only:

[ ] In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, I specifically authorize a trained school staff member to administer the Epi-Pen and call 911.

Parent/Guardian Signature:_____Date:_____

To be completed by STUDENT:

- I plan to keep my medication and 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.
- I will notify a school staff member if I self-administer my medication, or if I am having more difficulty than usual with my health condition.

Student Signature:_____Date:_____

Raleigh Charter High School

Student Name: **Date of Birth:** **School:** **School Year:**

	Diagnosis	Medication Name **Right** Medication	Dosage **Right** Amount	How to Give **Right** Route	When to Give **Right** Time	Medication Log Date/Time Given/Staff Initials
Daily	Diagnosis ☐ _____ ☐ _____					
Allergy	List of Allergens:	☐ Diphenhydramine (Benadryl) ☐ Other _____	☐ Dose _____	☐ By Mouth ☐ Other _____	☐ Upon Exposure ☐ Mild Reaction	
		☐ Epinephrine Auto-Injector	☐ 0.15 mg ☐ 0.3 mg	Intramuscular (IM) Injection	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, **repeat dose after _____minutes if symptoms continue**	
Asthma	Green Zone Exercise Induced	☐ Albuterol ☐ Other _____	☐ 2 puffs ☐ 1 ampule/vial ☐ Other _____	☐ Inhaled (use spacer if provided) ☐ Nebulizer	☐ DAILY before exercise ☐ AS NEEDED before exercise ☐ Other _____	
	Yellow Zone	☐ Albuterol ☐ Other _____	☐ 2 puffs ☐ 4 puffs ☐ 1 ampule/vial ☐ Other _____	☐ Inhaled (use spacer if provided) ☐ Nebulizer	☐ Every 4 hours as needed ☐ Other _____	
	Red Zone **CALL 911**	☐ Albuterol ☐ Other _____	**CALL 911** ☐ 4 puffs ☐ 1 ampule/vial ☐ Other _____	☐ Inhaled (use spacer if provided) ☐ Nebulizer	☐ For Emergency Symptoms	
	Other Asthma Medications (Example - Symbicort, Dulera, etc.)	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ with Spacer	**Please complete with specific numbers of puffs and minutes – no ranges** ☐ Exercise: __ puff(s) inhaled before exercise as needed to prevent symptoms ☐ Yellow Zone: __ puff(s) inhaled every __ minutes for cough/wheeze/shortness of breath, up to __ puffs Call parent/guardian if symptoms have not improved after __ puffs ☐ Red Zone: Call 911 – __ puff(s) inhaled every __ minutes up to __ puffs			
	Diabetes	☐ Glucagon ☐ GVoke ☐ Baqsimi ☐ Other _____	☐ Dose _____	☐ Subcutaneous SQ ☐ Intramuscular IM ☐ Nasal Spray ☐ Other _____	If student becomes unconscious	
	Seizure	☐ Diastat ☐ Valtoco ☐ Nayzilam ☐ Other _____	☐ Dose _____	☐ Rectal Gel ☐ Nasal Spray ☐ Other _____	☐ Seizure Onset ☐ After 5 minutes ☐ After____ minutes ☐ Other _____	

Physician's Printed Name:	Physician's Telephone:	Date:
Physician's Signature:	Physician's Fax:	MD Stamp:

PARENT/GUARDIAN MUST SIGN *"To be completed by parent"* SECTION ON THE BACK THIS FORM