

**Decatur County Community Schools
North Decatur Jr.-Sr. High School**

Authorization to Carrying & Self Administer Medication

A student may possess and self-administer medication for chronic diseases or medical conditions provided the student's parent/guardian and health care provider files a written authorization with the school. A new written authorization must be filed each school year.

PHYSICIAN'S ORDER FOR MEDICATION

Student Name _____ Date of Birth _____

School Yr. _____ Grade _____

Diagnosis

Medication _____ Dose _____ Method of

Administration _____

Time or Indication for Administration

Side Effects to Report

Other Recommendations

Start Date _____ End Date _____

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

Physician Signature

Print Name

Phone

Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and/or self-administer the above ordered medication. I take responsibility for this permission and I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, name of medication, strength, dose, and directions for use. I understand that the school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. In this event, I will be contacted by the nurse as soon as possible.

Parent Signature

Date

Student Signature

Date