AUTHORIZATION FOR SELF-CARRY BY UCPS STUDENTS
EMERGENCY MEDICATIONS

Student's Name: _____ **Birthdate**: _____

Medication: _____ **for** _____

Eligibility: Only students with diagnosed asthma, diabetes and/or severe allergies who may require medically prescribed rescue medications (i.e., inhaler, glucagon, insulin, epinephrine, dose of antihistamine).

- -

Healthcare Provider: This student is capable of and has been instructed on how to self-carry and, **if applicable**, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities. In the event of an emergency, this student may need assistance by a school staff member in the administration of this medication.

Healthcare Provider Signature/Date_____

Parent/Guardian: I give consent to the Union County Public Schools to allow my child to self- carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve the Union County Board of Education and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent Signature/Date _____

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when epinephrine or antihistamine is used, or if I use an inhaler and it does not bring relief of symptoms.

Student Signature/Date _____

School Health Nurse: I have reviewed this request and agree that this student should be capable of safely self-carrying and, when applicable, self-administering this medication.

School Health Nurse Signature/Date _____