LANGSTON CHARTER MIDDLE SCHOOL

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

PLEASE PRINT SCHOOL YEAR _____

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION: _____

☐ EPI-PEN ☐ DIPHENHYDRAMINE PRIOR TO EPI-PEN ☐ INHALER ☐ SEIZURE RESCUE

REASON FOR TAKING MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):

_____

EXPIRATION DATE OF MEDICATION: _____ POSSIBLE SIDE EFFECTS: _____

Parents, please read carefully:

Working closely with our physician, we have decided to allow my child to self-administer and self -monitor the above medication while at school. My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school sponsored activities, and during before or after-school activities on school property. I realize that Langston Charter Middle School cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container clearly labeled with my child's name. Permission is granted to the principal and/or school nurse to share this information with the individuals who have responsibility for my child. I give the school nurse permission to contact the physician's office to request medical information concerning my child.

Legal Guardian's Signature: _____ Date: _____

Physician, please read carefully:

I agree that his student must allowed to have the above-named medication on his/her person during school hours, at school-sponsored activities, and before or after-school activities on school property. This child has demonstrated competency in self-monitoring and self-administration of this medication. The parent is aware that Langston Charter Middle School cannot be responsible for any adverse outcome of this action.

Physician Signature: _____ Date: _____

Office phone #: _____