AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER SCHOOL ACTIVITIES
FT. KNOX COMMUNITY SCHOOLS
FT. KNOX, KY 20121

School policy does not allow students to carry and self administer medication on his/her person except under certain circumstances. A responsible, trained student may carry and/or self-administer medication for asthma (wheezing), severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life threatening situation with a written order of a physician, parent permission, and the school nurse and principal approvals.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER
(Must be filled out completely.)

Student Name _____ DOB_____ School_____

Address_____Grade_____

Condition for which the medication is administered_____

Name of medication, dose and method administered_____

Time or indication for administration_____

Is this a controlled drug? _____Yes_____No

Side effects to be noted/reported _____

Duration (dates) of administration: From _____To_____ (Limit of one school year)

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

_____ _____ _____ _____
Physician Signature Print Name Telephone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to _____carry_____self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

_____ _____ _____ _____
Parent Signature Date Student Signature Date
Parent Telephone Numbers Father: _____Home_____Work_____Cell
Mother: _____Home_____ Work_____Cell

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

_____ _____ _____ _____
School Nurse Signature Date Principal Signature Date