Fulton County Schools
Where Students Come First

Student Health Services

Authorization for Students to Carry a Prescription Inhaler, EpiPen, Insulin, or Other Approved Medication*

______________________________ ***(student name)*** needs to carry the following prescription-labeled inhaler, epipen, insulin, and/or ________________________ prescription medication with him/her.

I have been instructed in the proper use of my prescription-labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept the responsibility for notifying the Clinic Assistant or School Nurse each time I take my medication.

____ ______________________________

Student's Signature **Date**

(We strongly encourage each student to keep a second prescription inhaler, epipen, additional insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Fulton County School System and its employees of any legal responsibility when the above named student administers his/her own medication.
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing provider if indicated or needed.

____ ______________________________

Parent/Guardian Signature **Date**

Healthcare Provider and Parent/Guardian: ***Please turn form over for additional information and instructions.***

To be Completed by the Physician/Healthcare Provider

Medication Name & Purpose:

____
____
____
____

Prescribed Dosage:

____
____

Administration Instructions/Other Special Instructions:

____
____
____

Side Effects:

____
____
____

______________________________ ______________________

Physician's Signature **Date**

Physician's Name (*please print legibly*): ______________________________

Office/Contact Number: ______________________________

To Be Completed by Parent/Guardian

Emergency Contact Names & Numbers:

____
____
____

***Other Approved Medication – shall be defined as prescribed medication used for emergency purposes and/or medication approved by Student Health Services in collaboration with the student's health care provider.**

Fulton County School System reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

This form is effective only for the school year in which such authorization is granted; subsequent authorization may be granted in any school year in accordance with this policy.

______________________________ ______________________

Clinic Assistant/Cluster/Special Needs Nurse Signature **Date**

Revised 06/08