

**The Westview School
Health Services
2023-2024**

**AUTHORIZATION FOR STUDENT TO SELF-CARRY & SELF-ADMINISTER
EMERGENCY MEDICATION**

This form must be filled out completely and returned to the School Nurse with the medication before your child will be allowed to carry and administer their own inhaler/epi-pen/pancreatic enzyme supplement (PES). This form must be filled out **in addition** to any action plan, medical management plan, or medication request forms. This form is valid for one school year only.

Student Name: _____ Date of Birth: ____ / ____ / ____

Age: _____ Grade: _____ Teacher/ Homeroom: _____

To be completed by licensed healthcare provider:

Diagnosis: _____

Medication: _____

The above-named student is under my care. This student has a life-threatening medical condition and has been instructed in the proper management of their health condition. In addition, this student has demonstrated proper self-administration of this medication and has shown the skill level necessary to manage their own care.

_____ <i>Healthcare Provider Signature</i>	_____ <i>Printed Name</i>	_____ <i>Telephone</i>	_____ <i>Date</i>
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To be completed by parent/ legal guardian:

I request for my child to carry and self-administer the medication listed above during the school day, at school-sponsored activities, or while in transit to or from school. My child has demonstrated the necessary skill level to implement the care plan prescribed by their healthcare provider. I am responsible for providing all medications, supplies, and equipment my child may require for the administration of this medication. I understand that my child's medication must be in its original container, properly and clearly labeled by a pharmacist. I understand that this form is valid for this school year only.

By signing this form, I am indemnifying and holding The Westview School harmless against any injury or claims that arise as a result of my child's self-management of their life-threatening health condition. The School Nurse will contact the child's healthcare provider if there are questions or concerns about the child's healthcare condition and/or treatment. I am aware that the privilege of self-administration of this medication may be withdrawn if abused by the student. The Westview School reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate. EMS (911) will automatically be called anytime an epinephrine auto-injector has been administered, regardless of the signs/symptoms that are reported or observed.

_____ <i>Parent/ Legal Guardian Signature</i>	_____ <i>Printed Name</i>	_____ <i>Telephone</i>	_____ <i>Date</i>
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**AUTHORIZATION FOR STUDENT TO SELF-CARRY & SELF-ADMINISTER
EMERGENCY MEDICATION**

To be completed by student at school: *please initial next to each statement*

_____ I will keep my medication, supplies, and equipment with me at school.

_____ I will use my medication only as prescribed by my healthcare provider.

_____ I will not allow any other person to use my medication, supplies, or equipment.

_____ I will notify a Westview staff member if I am having more difficulty than usual with my health condition.

<i>Student Signature</i>	<i>Printed Name</i>	<i>Date</i>
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To be completed by school nurse:

_____ A nursing assessment has been completed with the above-named student. This student has demonstrated the necessary skills and knowledge required to self-carry and self-administer the medication that has been authorized by their healthcare provider.

_____ The authorized medication has been reconciled and is in its original container, clearly and properly labeled by a pharmacist.

<i>RN Signature</i>	<i>Printed Name</i>	<i>Date</i>
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