TREDYFFRIN-EASTTOWN SCHOOL DISTRICT

REQUEST FOR SELF-CARRY and/or SELF-ADMINISTRATION OF EMERGENCY MEDICATION

Healthcare Provider's Order

Please allow the following emergency medication to be carried and or self-administered on school property.

Self-Carry ONLY _____(Healthcare Provider initials)
Self-Carry and Self Administer _____(Health care Provider initials)*
**Health care initials indicate the student is competent and has demonstrated the capability to safely administer his/her/other own medication.*

Name of Patient/Student: _____

Name of Medication: _____

Dose and route: _____

Times for Administering: _____

Directions for Administering: _____

List Possible Side Effects and Treatment: _____

Date Prescribed: _____

Signature of Healthcare Provider: _____

Name of Healthcare Provider: _____

Address of Health Care Provider: _____

Phone Number: _____

The District reserves the right to preclude a student from possessing or self-administering medication in the school setting if the Responsible Personnel does not believe the student is capable of safely doing so based on student's age, cognitive function, maturity, behavior, etc.

Parent/Guardian Request

I request that my student _____be allowed to _____(initial) **self-carry** and _____(initial) **self-administer** his/her/other own emergency medication as prescribed. I request that TESD comply with the instructions of my student's healthcare provider. I relieve the school or any school district employee of any responsibility for the benefits or consequences of this self-carry and or self-administered medication and understand that the school or employees bear no responsibility for ensuring that the medication is taken.

Signature of Parent/Guardian _____ Date_____

Student Request (Self Administration only)

I acknowledge that I have received instruction from my healthcare provider on the proper safety for handling and disposal of the medications and or monitoring equipment. I will not allow other students to have access to my medication/ monitoring equipment. I understand it is my responsibility to immediately notify the school nurse of my use of my emergency inhaler or epinephrine auto injector. I understand that if I fail to abide by these requirements and responsibilities that I may lose privileges to self-carry and self-administer medications at school and during school sponsored events.

Student initials _____ Date _____
Signature of Student _____

Responsible Personnel (School Nurse) Self Administration only

I have reviewed this form and believe the student demonstrates that they can recognize their name, identify their medication, demonstrate proper technique for self-administration of prescribed emergency medications and monitoring equipment, and inform the health office when emergency medications are self-administered.

Responsible Personnel initials _____ Date _____
Signature of Responsible Personnel _____