



# Student Health Services SHS-2 Form

School Year: \_\_\_\_\_

**Authorization for Students to Carry a Prescription Inhaler, Epipen, Insulin, or Other Approved Medication\***  
*See Operating Guidelines on Medication Administration*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

*(PRINT LEGIBLY)*

**I AGREE TO THE FOLLOWING:**

- I need to carry the following prescription-labeled inhaler, Epipen, insulin, and/or approved medication \_\_\_\_\_.  
*(PRINT NAME OF MEDICATION LEGIBLY)*
- I have been instructed in the proper use of my 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 or medication, the privilege of carrying my medication may be reassessed and/or revoked. I also accept the responsibility for notifying the Clinic Assistant or School Cluster/Special Education Nurse each time I take my medication.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

*(Student Health Services strongly encourages 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.)*

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**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 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 happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container;
- I release Fulton County Schools System and its employees of any legal responsibility when supervising or assisting in this medication administration or 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**  
***(For Prescription Medication ONLY)***

<b>MEDICATION NAME:</b>	<b>PRESCRIBED DOSAGE:</b>
<b>POSSIBLE SIDE EFFECTS:</b>	
<b>ADMINISTRATION AND OTHER SPECIAL INSTRUCTIONS:</b>	
<b>CONDITION OR ILLNESS REQUIRING MEDICATION:</b>	

\_\_\_\_\_  
**Physician's Signature** \_\_\_\_\_  
**Date**

**Physician's Name (please PRINT legibly):** \_\_\_\_\_

**Office/Contact Number:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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**To Be Completed by Parent/Guardian**

**Emergency Contact Names and Numbers:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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**\*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 parent/guardian or healthcare provider.**

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

**This form is effective only for this school year and includes all school sponsored Fulton County Schools System activities and summer school.**

\_\_\_\_\_  
**Cluster/Special Education Nurse Signature**

\_\_\_\_\_  
**Date Received**

Revised December 2010