Student Health Services- SHS-2 Form

School Year: _____

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

(JGCD Operating Guideline on Medication Administration and Storage)

Student Name _____ Grade _____ DOB _____
(PRINT LEGIBLY)

I AGREE TO THE FOLLOWING: *(ONE MEDICATION PER FORM) – SUBMIT FORM TO THE SCHOOL CLINIC*

- 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 and/or medical supplies 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 Cluster School Nurse/ Special Education Nurse each time I take my medication. If on a field trip, I will notify the teacher/FCS staff chaperone.

_____ _____
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.)

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 School 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 (to include choking, allergic reaction, side effects and/or health risks related to this medication);
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing healthcare provider if indicated or needed.

_____ _____ _____
Parent/Legal Guardian Signature Print Name Legibly Date

Home Phone: _____ Work Phone: _____ Cell phone: _____

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