Bullard Independent School District
PO Box 250
Bullard TX 75757

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL

Board of Education policy permits a responsible trained student to carry and self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use with written order of physician, parent request, school nurse and principal approvals.

Name of Student _____ D.O.B_____ Date_____

Address _____Grade_____

Condition for which the medication/procedure is prescribed_____

Medication, dose, and method of administration_____

Time to administer medication/ procedure at school_____

Is this a controlled drug? _____Yes_____No

Side effects to be noted/reported _____

Other recommendations_____

Duration (dates) of administration: From _____to_____ (limit of one school year)

In my opinion, this student shows capability to carry and self-administer the above medication.

_____

Physician Signature Print Name Phone # Date

I request that my child, named above, be permitted to _____carry_____self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of student, prescribing health care provider, date of original prescription, strength and dose of medication, and directions for use.

_____ _____ _____ _____

Parent Signature Date Student Signature Date

_____

Parent Phone #s

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student is irresponsible with the medication. We will contact the parent as soon as possible in this event. *** The student must not share medication with another student.**

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School Nurse Signature Date Principal Signature Date