OUR LADY QUEEN OF APOSTLES REGIONAL CATHOLIC SCHOOL

PROVIDER ATTESTATION AND PARENT PERMISSIONS
FOR INDEPENDENT MEDICATION CARRY AND USE

(This form must accompany the medication order form for school administration.)

Directions for the Health Care Provider: This form may be used **as an addendum** to the required medication order form for administration of medication in school. This form is to attest that the student is independent in medication administration and may self-carry his/her medication. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ DOB: _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. I understand that the school nurse may reassess and revoke this privilege if my child cannot consistently and responsibly take his/her medication as prescribed by the licensed prescriber.

Signature: _____ Date: _____