Academy of Our Lady Of Grace

AUTHORIZATION FOR STUDENT TO CARRY MEDICATION

School: Date:

Student's name: Grade/Teacher:

Health care provider: *(Physician, Physician Assistant, Nurse Practitioner)*

Name: _____
Address: _____
Telephone: _____ Fax: _____

Medication: Name/Route/Dosage: _____

Frequency/Time of administration/assistance: _____

Diagnosis: _____

Other medical conditions requiring medication: _____

Any special side effects, contraindications, adverse reactions to be observed:_____
_____

Any severe reaction that may occur if a pupil other than the above-named received an Epipen injection:

HEALTH CARE PROVIDER'S STATEMENT

I request that the above-named student be allowed to carry _____ at school. I have verified the student's knowledge and skill to safely possess and use the medication, as required by law.

_____ _____

☛Provider's Signature ☛Date

PARENT'S STATEMENT

I request that my child carry his/her medication at school. I will provide the school with an extra Epipen to keep in the health office.

_____

_____

☛Parents Signature ☛Date

Emergency parent contact phone number : _____

School Nurse's Signature: Date: