



# Student Health Services

## Authorization for Students to Carry a Prescription Inhaler, EpiPen, Insulin, or Other Approved Medication\*

\_\_\_\_\_ (*student name*) needs to carry the following prescription-labeled inhaler, epipen, insulin, and/or \_\_\_\_\_ prescription medication with him/her.

I have been instructed in the proper use of my prescription-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, the privilege of carrying my medication may be altered. I also accept the responsibility for notifying the Clinic Assistant or School Nurse each time I take my medication.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

*(We strongly encourage 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 prescribed 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 should happen, the privilege of carrying the medication may be altered.
- I release Fulton County School System and its employees of any legal responsibility 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**

**Medication Name & Purpose:**

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**Prescribed Dosage:**

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**Administration Instructions/Other Special Instructions:**

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**Side Effects:**

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**Physician's Signature** **Date**

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

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



**To Be Completed by Parent/Guardian**

**Emergency Contact Names & Numbers:**

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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 health care provider.**

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

**This form is effective only for the school year in which such authorization is granted; subsequent authorization may be granted in any school year in accordance with this policy.**

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**Clinic Assistant/Cluster/Special Needs Nurse Signature** **Date**  
*Revised 06/08*