AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

Round Rock ISD permits a responsible, trained student to carry and self-administer certain medications for immediate use in a life-threatening situation or for enzymes used in Cystic Fibrosis with a written order from a physician and parent, school nurse and principal signatures. A new completed form is required each school year.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student _____DOB _____ School _____
Address _____ Grade _____
Condition for which the medication is administered _____
Name of medication, dose, and method administered _____
Time or indication for administration _____
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 Telephone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry/self-administer the above ordered medication. I understand that the medication must be in the original container, labeled with the name of the student, prescribing physician and medication, dose of medication and directions for use. The medication must not be expired. If the medication is not a prescription, it must be in the original container and not expired. I understand that this medication may not be distributed by my child to anyone else and that I may be liable if my child does distribute this medication to anyone else. I understand that my child will be held responsible for the possession and control of the medication during the time he/she is under the school's jurisdiction. I understand that RRISD cannot be held liable for any misuse/abuse of the medication by my child. Therefore, I release RRISD from any responsibility for my child's actions with regard to the prescribed medication.

_____ _____
Parent Signature Date

_____
Parent Telephone Numbers

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 shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

_____ _____
Nurse Signature/Date Principal Signature/Date

EMS will be called when an epi-pen is administered