CONGRESSIONAL SCHOOL

## AUTHORIZATION FOR SELF-CARRY AND SELF-ADMINISTRATION OF MEDICATION

**STUDENT NAME:_____ DOB:_____ GRADE:_____**

Congressional School (the "School") allows students to self-carry and self-administer prescription medications when necessary, provided that (1) this *Authorization for Self-Carry and Self Administration of Medication* is signed by the student's parent(s)/guardian(s), the prescribing physician, and the student; and (2) the School is confident that the student is able to safely carry and administer the medication in a manner directed by the prescribing physician without additional direction from School personnel. This form must be submitted each school year in which a student requests these privileges. If granted by the School, this authorization will remain in effect for the full school year unless revoked by the School, the student's physician, or the parent(s)/guardian(s).

**PHYSICIAN AUTHORIZATION AND MEDICATION INFORMATION**

As the treating physician of the above-identified student (the "Student"), I certify as follows. I have prescribed the following medication to the Student and am authorizing the Student to self-carry and self-administer this medication while the Student is attending the School and all School-sponsored events and activities (including school trips).

Medication:_____

Dose:_____ Frequency/Time of Administration:_____

Reasons/Symptoms for which the medication is to be administered:_____

Intended effect:_____

Possible side effects:_____

Start date:_____ Stop date:_____

Where medication will be stored when self-carrying:_____

I have instructed the Student on the proper administration of the medication. I have determined, in my professional opinion, that the Student is capable of self-carrying and self-administering the medication consistent with my orders. I may revoke my authorization by providing written notice to the School.

PHYSICIAN SIGNATURE:_____DATE:_____

PHYSICIAN NAME:_____

**PARENT/GUARDIAN CONSENT**

I give permission for my child (the Student) to carry and self-administer the medication listed above by the above-identified physician, consistent with the School's policies. I affirm my belief that my child is sufficiently mature to handle this responsibility and capable of self-carrying and self-administering the medication. I have instructed my child on the proper administration of the medication and confirmed my child's comfort with self-carrying and self-administering the medication.

I have discussed with the prescribing physician any risks associated with my child self-monitoring and self-administering the medication. I understand that it is solely my and my child's obligation to monitor my child's condition and, in consultation with the prescribing physician, review the status of my child's condition and ability to self-carry and self-administer medication on a regular basis. I agree to keep the School appraised of any changes to my child's condition and capabilities and will promptly notify the School Nurse in these situations.

If the medication is an emergency/life-saving medication, I agree to provide an extra dose of the medication to the School, to be stored in the School Nurse's office. For all other medication, I understand that if I do not provide backup medication to the School, the only medication available for my child on campus will be that carried by my child. I have instructed my child to notify a member of the School's faculty and staff following the administration of medication. If the medication is epinephrine, I understand that the School will call 911 and request my child to be transported to the nearest hospital.

I understand that the privilege to carry and administer medication may be revoked at any time by the School, and I will be notified if this happens. I may also revoke my authorization by providing written notice of my intent to the School Nurse.

I fully understand, accept, and appreciate that allowing my child to self-carry and self-administer medication involves risk, including, but not limited to, serious bodily injuries. I knowingly and freely assume, on behalf of myself and my child, all risks associated with my child self-carrying and self-administering medication. I understand and agree that the School, including its health professionals, will not be liable for my child's misuse or loss of medication, or as a result of any injuries arising from the self-administration of the medication.

PARENT/GUARDIAN #1 SIGNATURE:_____ DATE:_____
PARENT/GUARDIAN #1 NAME:_____

PARENT/GUARDIAN #2 SIGNATURE:_____ DATE:_____
PARENT/GUARDIAN #2 NAME:_____

**STUDENT ACKNOWLEDGMENT**

I agree to only use my medication when needed and the way my physician has instructed. I know when and why to use my medication. I know how to self-administer my medication. I know the possible side effects of the medication; if I think I am experiencing side effects, I will alert a School faculty or staff member. I will not share my medication or allow anyone else to use my medication. I will carry my medication in its original, labeled prescription container. I will always know where my medication is. I will tell a School employee immediately if I use my EpiPen (epinephrine). I understand that if I do not comply with these expectations, I may have my self-carry and self-administration privileges revoked.

STUDENT SIGNATURE:_____DATE:_____
STUDENT LOCKER # (IF MEDICATION WILL BE STORED THERE):_____