Oxford Area School District
Authorization for Self-Carry/Administration of Inhaler or Emergency Medication

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student_____DOB_____School_____
Address_____Grade_____
Allergies_____
Condition for which medication is administered_____
Name of medication, dose and method administered_____
Time or indication for administration_____
Side effects to be noted/reported_____
Instructions that school personnel should follow if the medication does not produce expected relief_____
Other recommendations_____
Duration (dates) of administration: From_____To_____(Limit of one school year)
Severe reactions that may occur to another student for whom the medication is not prescribed, should he/she receive a dose of the medication_____
IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND/OR 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 take responsibility for this permission.

_____ _____ _____
Parent/Guardian Signature Date Telephone Numbers (home and work)

STUDENT CONTRACT

Responsibilities for Carrying Inhaler / Emergency Medication

Observed Yes	No	
___	___	Demonstrates correct use/administration
___	___	Recognizes proper and prescribed timing for medication
___	___	Does not share medication with others
___	___	Keeps medication in agreed location _____
___	___	Agrees to come to the building clinic after using inhaler/ emergency medication for evaluation

_____ _____
Student Signature Date

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 if there is a safety risk. We will contact the parent as soon as possible in this event.

_____ _____ _____ _____
Nurse Signature Date Principal Signature Date