



HAMPTON CITY SCHOOLS

Authorization to Carry and Self-Administer Medication

Dear Parent/Guardian:

If it is medically necessary for your child to carry and administer his/her own medication, your child must hand in this form with parts A and B fully filled out. Part C will be completed in the clinic with you child. Your child must be able to answer the questions in Part C or he/she will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the parents and prescriber's normal authorization form for administration of medication in school. **It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.**

A. To be completed by the licensed healthcare provider:

_____ has been instructed in the proper use of the following medication(s): _____
(Student's Name)

In my professional opinion, this student is responsible and should be allowed to carry and use the above medication(s) by him/herself.

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian:

I request that my child _____ be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medications(s) in his/her locker, as I consider him/her responsible. My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. **It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.** I will support my child in following the agreement in Part C.

(Parent/Legal Guardian Signature) (Phone Number) (Date)

C. To be completed by the school nurse:

Student responsibilities for carrying and using medication observed:

Yes No

- ____ Student is consistently able to:
 - ____ Name the medication;
 - ____ Identify the correct medication;
 - ____ Identify the purpose of the medication;
 - ____ Know the correct dosage;
 - ____ Identify the time the medication is needed;
 - ____ Describe what will happen if medication is not taken;
 - ____ Be able to refuse to take the medication if he/she has any concerns.
- ____ Student demonstrates the correct use/administration.
- ____ Student realizes his/her responsibility in carrying his/her medication(s) and agrees not to share the medication(s) with others.
- ____ Student agrees to come to the health office immediately with any questions/concerns/adverse side effects.

The student agrees to follow the above agreements. **The student understands that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.**

(Student's Signature) (School Nurse's Signature) (Date)