Hillsborough County PUBLIC SCHOOLS
Preparing Students for Life

Authorization For Student to Self-Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. This student has a life threatening illness and has been instructed in the proper management of his/her health condition. In addition, this student has demonstrated proper self-administration of medications, treatments and/or procedures and has shown the skill level necessary to manage their own care.

Telephone	*Printed Physician's Name*	*Signature*	*Date*

To be completed by parent:

I request for my child to carry and self-administer medications, treatment, and/or procedure, as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from school. My child has demonstrated the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, treatment, procedure equipment, and supplies for their life threatening health condition. Supervision will not be provided by the school. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the district harmless against any injury or claims that arise as a result of the student's self-management of life threatening health condition. School personnel will contact the child's healthcare provider if there are questions or concerns about the child's healthcare condition and/or treatment. I am aware the privilege of self-administration of medications, treatments, and procedures may be withdrawn if abused by the student. The district reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication, supplies & equipment with me at school. ☐ I will use only as prescribed by my healthcare provider. ☐ I will not allow any other person to use my medication(s) or procedure equipment. ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*

Distribution: Nurse
(Updated May 2020)