BCSC Form 6.0-31-2
Adopted 3-15-2004

Authorization to Carry and Self-Administer Medication

School _____ Age _____ Grade _____

Student's name _____

Medication that will be carried for emergency use and self-administered by above student:

_____

Acute or chronic medical condition _____

Year of diagnosis _____

Signs/symptoms of emergency need of treatment _____

Treatment needed _____

Further treatment needed _____

I certify that the above named student needs to carry medication to self medicate in case of a medical emergency.

_____
Physician/Recognized Medical Authority Signature

Office Phone Number _____ Date _____

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Parent Authorization

We, as the Parent(s) of the above student, request, authorize and give written permission for you to allow my child to carry and self-administer his/her medication in case of a medical emergency as prescribed by the physician. We agree to notify you immediately of any change in circumstances concerning administration of this medication.

Parent Signature _____

Date _____