Byng Schools
School Health Services

SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION

PARENT

I, request and authorize my child _____ to carry and/or self-administer
Student's name

His/her medication _____.
Name of medication

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times his/her medication as long as it is not an endangerment to him/her or others, and does not misuse the medication.
- I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.
- I understand that Byng School System is not liable for the child's failure to administer the medication or for any adverse effects from the medication that may incur as a result of the child not properly self-administering the medicine.
- I understand that I am responsible to supply the school with an emergency supply of the prescribed medications as needed for a life threatening condition.

_____ _____
Parent/Legal Guardian Signature Date

PHYSICIAN'S STATEMENT AND AUTHORIZATION

I, certify that _____ has a medical condition and/or potentially
Student's Name

threatening illness _____ and this student is capable of
Specify illness or condition

and has been given instruction in the proper method of self-administration of

_____.
Name of medication

_____
Physician/Licensed Prescriber Name (Please Print)

_____ _____
Physician/Licensed Prescriber Signature **Date**

FAX copy of this form is valid