AUTHORIZATION FOR STUDENTS TO SELF-CARRY
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Please fill out and complete both sections.

^ š µ v Ş a [• Name: _____ School year: _____

To Be Completed by Prescribing Health Professional

It is my professional opinion that _____

Is capable of carrying and self-administering the following medication:

Medication Name: _____

Dosage: _____

Frequency: _____

I recommend self-administration of this medication for the treatment of: _____

_____

Special Instructions or comments: _____

_____ _____

Health Care Provider Signature Date

_____ _____

Print Name Phone

To Be Completed by Parent / Guardian

I, _____ my child _____ to carry and/or self-administer their _____ medication.

This authorization is based on the following:

x I hereby give permission to my child to self-administer prescribed medication at camp or class.

x I authorize release of information related to my Z] o health / medications between the Community Education and the prescribing health care provider.

x I understand that my child shall be permitted to carry

_____ _____