AUTHORIZATION FOR STUDENTS
TO CARRY MEDICATION

Date: 05/22/2014

As provided for in Douglas County Board of Education Policy JGCD and Regulation JGCD-R, _____, _____,
(Student Name) (Date of Birth)
needs to carry the following labeled medication with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

_____ _____
Medication Dosage and Directions

_____ _____
Physician's Signature Date

I have been instructed in the proper use of my labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my medication, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school health monitor to keep her informed of use of my medication in case I start having problems.

_____ _____
Student's Signature Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Douglas County School system and its employees of any legal responsibility when the above named student administers his/her own medication.

I authorize exchange of information/communication between the prescribing physician and Douglas County School System Health Services Coordinators regarding any prescription medication(s).

_____
Parent/Guardian Signature Date

Reviewed by School Nurse_____
Date

School Administrator's Signature _____
Date