THE SCHOOL DISTRICT OF LEE COUNTY
HEALTH SERVICES

Authorization to Carry and Self-Administer Medication & Carry Diabetic Supplies

Dear Parent/Guardian:

In order for your child to carry and administer his/her own diabetic medication(s) your child must hand in this form with parts A and B fully filled out. Part C will be completed in the health office with your child. Your child must be able to answer the questions in Part C or he/she will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the parent and licensed prescriber's normal authorization form for administration of medication in school.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the following medication(s):
(Student's Name)

In my professional opinion, this student is responsible and should be allowed to carry and use the above medication(s) by him/herself.

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) on his/her person or to keep the above-prescribed medication(s) in his/her locker, as I consider him/her responsible. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, *the privilege* of carrying his/her medication will be rescinded. I will support my child in following the agreement in Part C.

_____ _____
(Parent/Legal Guardian Signature) (Date)

C. To be completed by the school nurse:

Student responsibilities for carrying and using medication observed:

Yes	**No**	
___	____	Student is consistently able to: Name the medication; Identify the purpose of the medication; Know the correct dosage; Identify the time the medication is needed; Describe what will happen if medication is not taken. Be able to refuse to take the medication if he/she has any concerns. Knows the appropriate method of disposal for any sharp used
___	___	Student demonstrates the correct use/administration.
___	___	Student realizes his/her responsibility in carrying his/her own medication(s) and agrees not to share the medication(s) with others.
___	___	Student agrees to come to the health office immediately with any questions/concerns/adverse side effects.

The student agrees to follow the above agreement. He/she realizes that *the privilege* of carrying and administering his/her own medication(s) can be rescinded.

_____ _____ _____
(Student Signature) (School Nurse Signature) (Date)