

Brantley County School Health Services
Authorization for Student to Carry / Administer EMERGENCY MEDICATION
(e.g. epinephrine, insulin, prescription rescue inhaler, prescription rescue seizure med.)
2026 - 2027

Note: A completed form (one medication per form) must be provided to the school nurse/designee before the student may possess and use the medication during school.

Student Name: _____		Date of Birth: _____
School: _____	Grade: _____	Homeroom: _____
Does the student participate in afterschool activities? ☐ Yes ☐ No List: _____		
Medication Name: _____		Prescribed Dosage: _____
Time Due: _____		Route of Administration: _____
Diagnosis / Condition Requiring Medication: _____		
Possible Side Effects / Adverse Reactions: _____		
Other Special Instructions: _____		

Healthcare Provider Name: _____	Phone # : _____	Fax # : _____
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**** This section must be completed and signed by the parent/guardian.**

As the parent/legal guardian of the above named student, I hereby request authorization for possession and self-administration of the above named medication by this student while in school, at school-sponsored activities, while under supervision of school personnel, and while in before/after-school care on school-operated property. This student demonstrates full understanding of the proper use of his/her medication.

I understand that:

- The school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his/her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his/her medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty medication and devices.
- The school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with medication.
- The school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.
- The student is to accept the responsibility for notifying the school nurse/designee each time they take the medication. If on a field trip, the above named student will notify the school staff/chaperone.

I take sole responsibility for:

- The monitoring of medication, medication use, and refilling of prescriptions for medication, as the school will not be responsible for the supervising, recording, and monitoring of self-administered medication.
- Ensuring the student always carries his/her medication on his/her person.
- Deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- Informing school staff in writing of any changes in the student's treatment or management.
- Informing the school of any exacerbations, hospital visits, and/or new or changed student medical information.
- Informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- Coordinating distribution of the student's management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus drivers, before-school and after-school staff.)

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/her emergency medication.

Parent/Legal Guardian Name

Parent/Legal Guardian Signature

Date

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(continued →)

**** This section must be completed and signed by the student.**

As the above named student, I have been instructed in the proper use of my prescription emergency medication and fully understand how and when to use it. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I also understand that should another student use my medication, the privilege of carrying it may be reassessed and/or revoked. I accept the responsibility for notifying the school nurse/designee each time I take my medication. If on a field trip, I will notify the school staff/chaperone. I understand and agree to the terms of the school policy.

Student Signature

Date

**** This section must be completed and signed by the healthcare provider.**

The above-named student has been educated, trained, and demonstrates understanding of the proper use of his/her emergency medication. It is my professional opinion that the student be permitted to carry and self-administer his/her assigned medication.

Diagnosis / Condition Requiring Medication: _____

Medication Name: _____ **Prescribed Dosage:** _____

Time Due: _____ **Route of Administration:** _____

Possible Side Effects / Adverse Reactions: _____

Other Special Instructions: _____

Healthcare Provider Signature

Date