2026-2027 School Year

Authorization for Self-Carry and Administration of Emergency Medications

6th-12th Grade Students

(PARENTS OF YOUNGER STUDENTS MAY CONTACT THEIR PRINCIPAL WITH SPECIAL REQUESTS AND DETERMINATIONS WILL BE MADE ON A CASE-BY-CASE BASIS)

Student Name _____ Birth Date _____ Grade _____

THIS SECTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN

I authorize Dayspring Christian Academy to allow my student to possess and use his/her prescribed medication

a. While in school
b. While at a school-sponsored activity
c. While under the supervision of school personnel
d. Before or after school hours

1. I agree that my student will notify the school nurse immediately following each use of the prescribed medication.

2. I acknowledge that the school bears no responsibility for ensuring that the medication is taken or properly self-administered. It is recommended, for the protection of the student, that an additional dose or container of the medication is kept in the health room in case the student does not have his/her medication.

3. In accordance with Pennsylvania law, I hereby release Dayspring Christian Academy, its board, employees, and agents from any financial or medical liability regarding adverse reactions, injuries, or issues resulting from my child's self-administration of this medication.

4. I understand that it is my student's responsibility to protect his/her medication from being left in an area where it is accessible to other students.

5. I agree that if my student abuses or ignores this policy, school personnel may confiscate the medication and the school may require that it be kept with the school nurse.

I give permission for my student to carry and self-administer his/her prescribed medication: Yes No

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____

Student Acknowledgement

I acknowledge that carrying and self-administering medicine at school or a school-sponsored activity is a privilege that may be lost if not exercised responsibly and safely, as determined by the school nurse and administration, and that the authorization for me to carry and self-administer the medication noted above may be revoked at any time if I fail to comply with the rules set forth. **I agree to immediately report to the school nurse, a teacher, or a principal every single time I use this emergency medication so they can check my health status.**

Signature of Student:_____ Date:_____

Continued on next page/back

THIS SECTION IS <u>REQUIRED</u> TO BE COMPLETED BY THE PRESCRIBING HEALTH CARE PROVIDER

Diagnosis/Medical Condition:_____

Medication _____ Route _____

Dosage to be administered _____ Start Date _____ End Date _____

Frequency_____For PRN(as needed) meds, list trigger symptoms:_____

Side Effects/Contraindications_____

Special instruction for storage or administration of medication _____

I certify that this student has a life-threatening condition, has been instructed on proper device technique, is competent, adequately skilled and responsible enough to self-administer and self-carry the listed medication, and is medically cleared to carry this medication on their person at school. Yes No

Physician's Name (print) _____ Phone Number _____

Physician's Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY THE SCHOOL NURSE

[ ] Student has demonstrated correct technique and knowledge of medication timing/dosage.

[ ] Student has signed and understands the acknowledgement section

[ ] Individualized Healthcare Plan (IHP) / Emergency Action Plan is on file, if applicable.

A back-up supply of this medication has been provided to the health office: [ ] Yes [ ] No [ ] N/A

School Nurse Signature: _____ Date: _____