

East Side Union High School District
Health Services

AUTHORIZATION TO CARRY AND SELF-ADMINISTER EMERGENCY MEDICATION ON CAMPUS:
TO BE COMPLETED BY PHYSICIAN AND PARENT/GUARDIAN

(Only to be used in conjunction with SCHOOL MEDICATION ADMINISTRATION: PHYSICIAN AND PARENT /GAURDIAN AUTHORIZATION)

_____ has been instructed in use of _____
Student's Name Name of Medication

We, _____ and _____,
Physician Parent/Guardian

Request that this student be permitted to self-administer this prescription medication and to carry it on his/her person or to keep it in his/her locker or PE locker. The student has been trained and understands the purpose and appropriate method, frequency, dosage and use of this medication.

We, the undersigned, release East Side Union High School District and its employees of any and all liability resulting from this student's possession and self-administration of this medication. We acknowledge that the District assumes no supervisory responsibility over the student's self-administration of the above-listed medication(s).

This form must be completed in addition to the routine *School Medication Administration: Physician and Parent/Guardian Authorization* form and must be renewed each school year.

I give East Side Union High School District permission to contact the Physician listed above concerning this medication.

Physician's Signature Date

Parent/Guardian Signature Date

Physician Telephone

Parent Daytime Telephone