Wissahickon School District

True Blue with a Heart of Gold

Permission to Carry and Self-Administer Emergency Medication

Please complete this form if the student will carry or carry and self-administer an emergency medication. Unsupervised self-administration of emergency medication refers to situations in which students carry their own medication and administer it to themselves during the school day/school event, as ordered by their Licensed Prescriber and as authorized by their parent/guardian.

Name of Student: _____ Date of Birth: _____

School: _____ Grade/HR: _____

Name of Medication: _____

Dose: _____ Reason for Medication: _____

Consent/Permission from Parent/Guardian: Please check on box from the following two options.

☐ It is necessary for my child to carry their own emergency medication as listed above (epi pen, "rescue type" asthma inhaler, emergency medication for diabetes). My child is competent to carry the medication but is **NOT competent to self-administer** the emergency medication.

If responsible personnel through professional judgement and assessment believe that the student Is not capable of safely carrying the emergency medication, the parent and Licensed Prescriber will be contacted and alternate arrangements will be made.

OR

☐ It is necessary for my child to **carry AND self-administer** their own emergency medication listed above (epi pen, "rescue type" asthma inhaler, emergency medication for diabetes). My child is competent to carry AND self-administer the medication.

If responsible personnel through professional judgement and assessment believe that the student is not capable of safely carrying AND self-administering the emergency medication, the parent and Licensed Prescriber will be contacted and alternate arrangements will be made.

The student must notify responsible personnel after each use of emergency medication.

Print name of parent/guardian: _____

Signature of parent/guardian: _____

Phone number: _____ Date: _____

M5/M6/2025

OVER: both sides must be completed

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Name of Student: _____ Date of Birth: _____

School: _____ Grade/HR: _____

Name of Medication: _____

Dose: _____ Reason for Medication: _____

To be completed by Licensed Prescriber:

Consent to Carry Emergency Medication: Please check one box from the following two options.

☐ **Permission for student to carry (not self-administer) emergency medication**

It is necessary for the student named above to carry the prescribed medication listed above. The student is capable of carrying the emergency medication.

If responsible personnel through professional judgement and assessment believe that the student Is not capable of safely carrying the emergency medication, the parent and Licensed Prescriber will be contacted and alternate arrangements will be made.

OR

☐ **Permission for student to carry AND self-administer emergency medication**

It is necessary for the student named above to carry and self-administer the prescribed emergency medication named above. The student is capable of carrying and self-administering the emergency medication.

If responsible personnel through professional judgement and assessment believe that the student is not capable of safely carrying AND self-administering the emergency medication, the parent and Licensed Prescriber will be contacted and alternate arrangements will be made.

Print name of Licensed Prescriber: _____

Signature of Licensed Prescriber: _____

Phone Number: _____ Date: _____

M5/M6/2025

OVER: both sides must be completed