



# Student Health Services SHS-2 Form

School Year: \_\_\_\_\_

## Authorization for Students to Carry a Prescription Inhaler, Epinephrine, Insulin, or Other Approved Medication\*

*(JGCD Operating Guideline on Medication Administration and Storage)*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

*(PRINT LEGIBLY)*

**I AGREE TO THE FOLLOWING: (ONE MEDICATION PER FORM) – SUBMIT FORM TO THE SCHOOL CLINIC**

- I need to carry the following prescription-labeled inhaler, epinephrine, insulin, and/or approved medication \_\_\_\_\_  
*(PRINT NAME OF MEDICATION LEGIBLY)*
- I have been instructed in the proper use of my labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication and/or medical supplies under any circumstances. I also understand that should another student use my prescription or medication, the privilege of carrying my medication may be reassessed and/or revoked. I also accept the responsibility for notifying the Clinic Assistant or Cluster School Nurse/ Special Education Nurse each time I take my medication. If on a field trip, I will notify the teacher/FCS staff chaperone.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

*(Student Health Services strongly encourages each student to keep a second prescription inhaler, Epipen, additional Insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)*

### To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this medication at school:

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container;
- I release Fulton County School System (FCS) and its employees of any legal responsibility when supervising or assisting in this medication administration or when the above named student administers his/her own medication (to include choking, allergic reaction, side effects and/or health risks related to this medication);
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing healthcare provider if indicated or needed.
- Pursuant to FCS Medication Administration Policy, Middle School students may carry the following over-the-counter medications with the completion of this form: Acetaminophen, Antacids, Aspirin, Cough or Throat Lozenges, Ibuprofen, Midol or Oral Antihistamines. (High School Students may also carry these approved medications but no form is required). These medications must be kept in the original containers.

\_\_\_\_\_  
Parent/Legal Guardian Print Name Legibly Date

Signature

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Healthcare Provider and Parent/Guardian: Please turn form over for additional information and instructions.**

