



*Student Health Services*

**Authorization For Students to Carry A Prescription Inhaler,  
EpiPen, Insulin, Or Other Approved Medication\***

\_\_\_\_\_ (student) needs to carry the following prescription labeled inhaler, epipen, insulin, and/or \_\_\_\_\_ prescription medication with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

(We strongly encourage each student to keep a second prescription inhaler, epipen, additional insulin or other prescribed medication in the school clinic in case of emergency and in the event the first is lost or left at home.)

**Please turn form over for additional information and instructions  
(Health care provider and parent)**

I have been instructed in the proper use of my prescription 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 under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept the responsibility for notifying the Clinic Assistant or School Nurse each time I take my medication.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this prescribed 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 should happen, the privilege of carrying the medication may be altered.
- I release Fulton County School System and its employees of any legal responsibility when the above named student administers his/her own medication.
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing provider if indicated.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Turn form over**

**To be completed by the physician/health care provider:**

**Medication Name & Purpose:**

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**Prescribed Dosage:**

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**Administration Instructions/Other Special Instructions:**

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**Side Effects:**

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Physician's Signature

Date

Office/Contract Number: \_\_\_\_\_

**Parent/Guardian to complete:**

Emergency Contact Numbers:

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**\*Other Approved Medication – shall be defined as prescribed medication used for emergency purposes and/or medication approved by Student Health Services in collaboration with the student's health care provider.**

**Fulton County School System reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.**

**This form is effective only for the school year in which such authorization is granted; but subsequent authorization may be granted in any school year in accordance with this policy.**

\_\_\_\_\_  
Clinic Assistant/School Nurse Signature

\_\_\_\_\_  
Date

Revised 04/05

