ANDERSON SCHOOL DISTRICT TWO

I. AUTHORIZATION FOR MEDICAL PROCEDURES AT SCHOOL

MUST BE SIGNED BY LEGAL GUARDIAN AND PHYSICIAN

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

PHYSICIAN TREATING STUDENT FOR THIS CONDITION: _____

PROCEDURE REQUESTED BY PARENT: _____

STUDENT'S PRIMARY DIAGNOSIS AND REASON FOR THIS PROCEDURE:

_____

SPECIFIC INSTRUCTIONS FROM THE PHYSICIAN FOR THIS PROCEDURE:

_____

REQUIRED AND PRESCRIBED MEDICATIONS ASSOCIATED WITH THE PROCEDURE:

_____

PRECAUTIONS OR SIDE EFFECTS: _____

TIME SCHEDULE AND/OR INDICATIONS FOR THIS PROCEDURE: _____

THIS PROCEDURE SHOULD BE DONE BY:

☐ NURSE ☐ NURSE AND STUDENT ☐ STUDENT ALONE (See Part II)

DATE TO **START** PROCEDURE: _____ DATE TO **STOP** PROCEDURE: _____

By my signature, I verify that I have recommended or prescribed the above-referenced medical procedure and the above terms and instructions for administering this procedure.

PHYSICIAN SIGNATURE: _____ DATE: _____

I am requesting and give my consent for my child to receive the above-referenced procedure at school. I will provide all medication, equipment, and supplies in order for my child to have this procedure at school. I also understand that I must notify the school immediately if the health status of my child changes, if we change physicians, or if the procedures are changed or cancelled. I hereby give my permission for the exchange of confidential, protected health information between the above-named physician and the school.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

II. SELF ADMINISTRATION AND SELF MONITORING OF PROCEDURE

(SECTIONS I AND II MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN AND PARENT IF THE STUDENT IS TO SELF-ADMINISTER THIS PROCEDURE DURING SCHOOL HOURS.)

By my signature below, I am indicating that this student has been instructed and is competent to self-monitor or self administer the above-referenced procedure, including any medications necessary for the procedure, and the student and parents have been instructed regarding the risks involved in over-medicating or improperly self-monitoring the student's condition or self-administering the procedure, as well as the dangers of use of the student's supplies, equipment, or medication by other students for whom this procedure or medication is not prescribed.

Physician Signature _____ Date: _____

PARENT/GUARDIAN AND STUDENT

I represent that my child has been trained by a health care provider and is competent to self-administer or self - monitor using the above-referenced procedure and/or medication as noted above in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school sponsored activities, and during before-school or after-school activities on school-operated property.

I understand that permission for my child to self-administer and/or self-monitor provides authority for my child to administer a medication and/or procedure or monitor himself or herself without supervision by a nurse or a school official trained by a nurse to assist students with medications or procedures.

I understand that my child must keep any medications, including those necessary for a procedure, in the container provided by the pharmacist who filled the prescription or my child's health care practitioner. The container must have my child's name, the name and the dosage of the medication, and the directions for proper use on it. Whenever practical and reasonable, supplies or equipment necessary to monitor or administer a procedure may be kept with the child in a container with the student's name, name and quantity of the supplies or equipment, and the directions for proper use.

I understand that my child will be unable to self-administer or self-monitor the above-referenced procedure or medication if he/she endangers himself/herself or another student by misusing any equipment, supplies, or medication(s).

I understand that permission to self-administer and/or self-monitor will be reviewed and granted on at least a year-by-year basis provided Anderson County School District Two's guidelines are met.

Legal Guardian Signature: _____ Date: _____

I understand my responsibilities for self-monitoring or self-administration of the above-referenced procedure and/or medication. I understand that the equipment, supplies, or medication are to be kept with me at all times and are not to be shared with other students at any time. I understand that misusing my equipment, supplies, or medication will result in my being unable to self-administer and/or self-monitor.

Student Signature: _____ Date: _____