City of Cape Coral Charter School Authority

Health Services

Authorization to Carry & Self-Administer Medication

Student Name: _____ DOB: _____

Grade/Teacher: _____

To be completed by Licensed Healthcare Provider:

The above medication(s) may be carried & self-administered by the named student.

_____ _____

Licensed Healthcare Provider Signature | Licensed Healthcare Provider Name

_____ _____ _____

Phone Number | Fax Number | Date

To be completed by Parent/Legal Guardian:

By signing, I understand that I am stating that my child has been instructed and understands the purpose, frequency and use of his/her medication, and will use this medication only as instructed. My child understands that he/she are responsible and accountable for carrying and using his/her medication. This includes carrying medication with him/her during field trips and off-campus activities. It is understood that if there is irresponsible behavior or a safety risk, the *privilege* of carrying his/her medication will be rescinded.

_____ _____

Parent/Legal Guardian Signature | Date

To be completed by the Student and School Nurse:

I understand the correct identification, purpose, dose, and how to administer my medication. I am aware of the responsibility in carrying my own medication and agree not to share my medication with others. I understand that it is my responsibility to keep my medication with me at all times including field trips and off-campus activities. If I need assistance with my medication or have questions, I will seek out help from the school nurse. I understand that my *privilege* to carry and administer my own medication can be rescinded.

_____ _____

Student Signature | Date

_____ _____

School Nurse Signature | Date