

**ARLINGTON INDEPENDENT SCHOOL DISTRICT**

1203 West Pioneer Parkway

Arlington, Texas 76013

**\*PARENT'S REQUEST FOR SELF-ADMINISTRATION OF EMERGENCY MEDICATION BY STUDENT\***

STUDENT \_\_\_\_\_ GRADE \_\_\_\_\_

DATE \_\_\_\_\_ SCHOOL \_\_\_\_\_

I request that my child, named above, be allowed to keep the following emergency medication:

\_\_\_\_\_

with him/her at all times as requested by the licensed health care provider. I understand that if my child allows another to use the medication, the privilege will be revoked. I agree to supply a backup dosage for the school clinic for use in an emergency.

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

WORK PHONE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

PAGER \_\_\_\_\_

**\*PRESCRIBER'S REQUEST FOR SELF-ADMINISTRATION OF EMERGENCY MEDICATION BY STUDENT\***

The school district is hereby authorized to allow the above-named student to carry the medication prescribed below on his/her person at all times. If medication must be used more often than indicated below, or if student's condition worsens, the student should notify clinic personnel who will contact the parent/guardian.

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Frequency and amount of dosage

Student should go to clinic if medication is needed more than \_\_\_\_\_ time(s) during one school day.

\_\_\_\_\_  
Signature of Prescriber

\_\_\_\_\_  
Printed Name of Prescriber

\_\_\_\_\_  
Phone Number of Prescriber

**SPECIAL INSTRUCTIONS:**

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\_\_\_\_\_

Martin High School Fax 817-561-8606  
Martin High School Nurse 682-867-8706