ARLINGTON ISD RESCUE MEDICATION REQUEST FORM

Students who require rescue medication to be with them at all times may be granted permission to self-carry the medication provided they are able to safely self-administer the medication and are able to be responsible for that medication. Rescue medication refers to epinephrine auto injectors and asthma inhalers. Other life-saving medication will be subject to approval by the nurse/district on a case-by-case basis.

I request that my child be allowed to self-carry and self-administer the medication ordered by their physician on this form. By my signature, I affirm that:

1. My child knows the name and dosage of his/her medication

2. My child knows the purpose of his/her medication

3. My child can administer his/her medication properly, for the appropriate purpose, in an appropriate dose given correctly

4. My child understands how to safely handle his/her medication

5. My child understands that his/her medication may not be used by anyone other than themselves. Allowing another to use the medication will revoke the privilege of self-carrying and may result in discipline.

6. My child understands when to report to the school clinic for his/her condition

7. I will provide a back-up supply of my child's medication to the school clinic to be used in an emergency

8. I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or Healthcare provider to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other AISD form requesting for school health services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by HIPPA rules. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of a parent/guardian, as outlined herein.

Last Name _____First Name _____ID #_____Grade_____

Parent Signature _____ Date _____ Mobile Phone _____

Work Phone _____ Home Phone _____Email _____

INFORMATION BELOW THIS POINT MUST BE COMPLETED IN ENGLISH

Medication Name	Dose	Route	Time(s) to Give

One medication per form

Student should report to the school clinic if medication is needed more than _____time(s) during the school day.

I affirm that this student knows when they should use their medication and can self-administer the medication safely and effectively.

Physician Signature _____Date _____

Physician Printed Name _____Phone _____Fax _____

Condition for which medication is being given: _____

Allergies/Special Instructions: _____

For Clinic Use Only

Initial Intake Count _____Signature _____Signature _____