MILE HIGH ACADEMY

Permission to Carry/Self-Administer Medication

Date:_____

STUDENT NAME:_____ DOB: _____

Medication_____Dosage_____

Route of Administration_____Time/Frequency_____

Purpose of Medication_____

Through my consultation with the above-named student's parent(s)/guardian(s), as well as my own assessment of the student, I have determined that the student is able to identify his/her correct medication, demonstrate correct self-administration of the above-listed medication, and has knowledge of the required dosage and timing/frequency of use of the medication. The student has knowledge of his/her condition and is sufficiently responsible and able to properly carry and self-administer the medication during the school day. The student has been instructed in the purpose, appropriate method, and frequency of use of the medication and is capable of self-administering the medication. A new form must be completed for all medication changes.

_____ _____

Physician Signature Date

_____ _____

Physician's Printed Name Physician's Telephone Number

It is understood that the medication will be self-administered solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardian(s) hereby agree(s0 to release Mile High Academy and its personnel from any and all claim(s), which they now have or may hereafter have arising relating to an act or omission of the student's use of the medication.

_____ _____

Parent or Guardian Signature Date

For students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions:

___ The School Nurse and the above-referenced physician have collaborated to formulate a health care management plan, which is attached to this form.

___ The School Nurse, the above referenced Physician and the Student have entered into a Permission to carry/self-administer medication Contract which is attached to this form.