WA-NEE Community Schools

A TRADITION OF EXCELLENCE

1300 North Main Street
Nappanee, IN 46550
(574)773-3131
(574) 773-5593 FAX

Physician Authorization for Self-Carry Emergency Medication in School

I have diagnosed _____ (**student name**) with_____ (**chronic disease**) for which emergency medication _____(**name of medication**) may be needed while at school or during school-sponsored activities.

I have instructed this patient how to safely and appropriately use this medication and I believe that they are capable of using the medication as instructed. I believe that this patient should carry this medication and will use it in a responsible manner, in accordance with my orders and instructions.

Physician Name: _____**Physician Signature:** _____
Date: _____

Student Responsibility:

_____ I plan to keep my emergency medication with me at school rather than in the nurse's office.
_____ I agree to use my emergency medication in a responsible manner, in accordance with my physician's orders.
_____ I will notify the nurse if I use my emergency medication.
_____ I will not allow any other person to use my emergency medication.

Student's signature: _____ School Year: _____

Parent Responsibility:
This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.
_____ I agree to see that my child carry his/her medication as prescribed; that the device contains medication and the medication is not expired.
_____ It has been recommended to me that back-up medication be provided to the nurse's office for emergencies.
_____ I will review the status of the student's health condition on a regular basis.

Parent Signature: _____ Date: _____

Rev. 2018

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