INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number **506.2.2.1.2.2P** Adopted **February 1990** Revised **July 2012**

Title **Authorization for Student Possession and Self-Medication with Inhaler, EpiPen and/or Insulin at School**

Name of child_____

School_____ School year_____

Physician's Order for Student and Self-medication

Name of medication_____

Dosage_____

Time/frequency_____

Reason for medication_____

Possible side effects_____

Estimated termination date_____

The student is knowledgeable about the medication noted above and how to self-administer the medication.

Signature_____ Date_____
physician

Address_____

Telephone number_____

As authorized by my child's physician, I request that my child be allowed to carry and self-administer the prescribed medication noted above. I understand my child must carry this medication at all times in school or he/she will lose the right to carry and self-administer the medication at school.

Signature_____ Date_____
parent or guardian