Harvest Christian Academy
Health Services

Parent/Guardian Permission to Carry Meds at Secondary School

Secondary students may carry over the counter medications (Tylenol, ibuprofen, Midol, etc.) and some prescription medications (ex. antibiotics.) To do so, they need to:

1. Keep the medication in the original container.
2. Carry a written note from the parent/guardian naming the medication(s) and instruction for its use. The note should include; date, parent/guardian signature and phone number. You may use the permission form below.
3. **DO NOT SHARE MEDICATION(S) with anyone!!**

In order to carry **INHALERS, EPI-PENS** and **DIABETIC SUPPLIES**, you must submit a Medication Self Carry Agreement completed by the parent/guardian and doctor.
Students may NOT carry controlled substances at any time. All controlled substances, including behavior modification drugs, must be kept and administered by the school nurse. If your child requires this medication at school, please contact your nurse for the appropriate forms. Thank you.

----------Cut on line and give below to student----------

Medication Permission Form Date

I, _____(parent/guardian) give permission for _____(student) to carry and take_____(medication name). S/he may take _____(quantity) every _____hours, for the following symptoms_____ _____. Start date_____ End date_____

Please list all other medications s/he currently takes_____.

I have discussed the following with my student:
o Why, when and how to take this medication.
o The side effects of this medication.
o The districts medication policy on NOT SHARING MEDICATION WITH OTHERS.

_____Parent/Guardian Signature Day Contact Phone Number_____

Harvest Christian Academy
Emergency Medication Self-Carry Agreement

This plan is in accordance with HB 1688 from the 2001 Texas Legislative Session. This bill allows students to self-administer emergency rescue medication while at school or school functions with permission from parents, physicians, and the school nurse. This form is good only for the current school year and must be completed at the beginning of every school year.

Student Name: _____ Grade _____ DOB _____

Address: _____

Parent/Guardian: _____ Phone# _____ Phone# _____

Emergency Contact: _____ Phone# _____ Phone# _____

Treating Physician: _____ Phone# _____

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY STATE OF TEXAS

I ☐ have instructed _____ (student's name) in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry and self-administer the following emergency rescue medication while on school property or at school-related events:

Rescue Medications

Name:	Purpose:
Dosage:	When to Use:
Name:	Purpose:
Dosage:	When to Use:

For asthma inhalers only! May repeat for severe breathing difficulty ___ times ___ minutes apart.

Physician Signature_____ Print Name_____
Date_____ Office Number _____ Fax Number _____

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her emergency rescue medication while on school property or at

school related events according to school district policy and the student agreement below. I authorize the school's registered nurse
and the prescribing physician to discuss and/or clarify this medication order, or in the interest of this student's health, to discuss his/her response to the prescribed medication as required by the Nurse Practice Act and Medical Practice Acts of Texas.:

Parent/Guardian Signature _____ Date: _____

C. TO BE COMPLETED BY STUDENT AND SCHOOL NURSE

____ Student knows name, correct dosage, purpose, expected effects and side effects of medication.
____ Student demonstrates correct use/administration of medication.
____ Student understands that medication must have prescription label affixed, that authorization from the school nurse must be carried, that allowing anyone else to use this medication will result in disciplinary action, and that the PRIVILEGE of carrying this medication can be rescinded for violating any part of this agreement.

Student will carry/keep medication_____
Specify location

_____	_____	_____
Student Signature	School Nurse Signature	Date