CENTRAL WESTMORELAND CAREER & TECHNOLOGY CENTER
EMERGENCY MEDICATION SELF-ADMINISTRATION PERMISSION FORM
(Possession and Self-Administration of Asthma Inhalers, Insulin, Glucagon, and Epinephrine Auto-Injectors)

Student Name ____Grade_________AM / PM

Home School ______________________________Program ____________Instructor__________________

The following is required for your student to possess and self-administer any emergency medication at school and during all on/off campus school functions (ie: field trips, Skills competitions, etc): A written physician's order, a written consent/acknowledgement from the parent/guardian, and student. This form must be completed in its entirety and returned to the school nurse prior to medications being self-carried or self-administered. All medications must be in their original containers, appropriately labeled, safely stored, and supplies properly disposed of in appropriate containers.CWCTC may revoke or restrict a student's privileges to possess and self-administer any medication due to non-compliance with school rules, unwillingness, or inability of the student to safeguard the medication from other students.

A. Parental/Guardian Consent

I give permission for this student to self-carry and self-administer the medication ordered below by a licensed prescriber during the school day. I release CWCTC and its employees of any responsibility for the benefits or consequences of this medication and acknowledge that the school entity bears no responsibility for ensuring that the medication is taken.

I acknowledge that this student has received instruction from a medical provider on proper use and safety precautions for the listed medication, including acknowledgement that the student will not allow other students to have access to the prescribed medication and that s/he understands appropriate Safeguards.

Parent/Guardian Signature: ____ Date____________________

Parent/Guardian Printed Name: ____________________________________Phone ____________________

Student Signature:____Date_____________________

B. Licensed Prescriber Medication Order

Student Name ____ Date___________

Medication____Route/Dosage_________________

Time of Administration ______________________Demonstrated proper use and safety precautions__YES__NO

Allergies____

Side Effects____

Licensed Prescriber Signature ____

Prescriber Name Printed ____

Address____ Phone _________________________________

Updated 9/28/23