Montana Authorization to Carry and Self-Administer Medication

For this student to carry and self-administer medication on school grounds or for school sponsored activities, this form must be fully completed by the prescribing physician/provider and an authorizing parent, an individual who has executed a caretaker relative educational authorization affidavit, or legal guardian.

Student's Name:_____ School: _____
Sex: (Please circle) Female/Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____(Renew each year)

Physician's Authorization:
The above named student has my authorization to carry and self administer the following medication:
Medication: (1) _____ Dosage: (1) _____
(2) _____ (2) _____

Reason for prescription(s): _____
Medication(s) to be used under the following conditions: _____
_____

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his own without school personnel supervision. I have provided a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician Physician's Phone Number Date

Backup Medication – The law provides that if a child's health care provider prescribes "backup" medication to be kept at the school, it must be kept in a predetermined location, known to the child, parent, and school staff.

The following backup medication has been provided for this student: _____

For Completion by Parent, an individual who has executed a caretaker relative educational authorization affidavit, or Guardian

As the parent, individual who has executed a caretaker relative educational authorization affidavit, or guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used an auto-injectable epinephrine, he/she understands the need to alert an adult that emergency medical personnel need to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult.

I also acknowledge that the school district or nonpublic school may not incur liability as a result of any injury arising from the self-administration of medication by the student and that I shall indemnify and hold harmless the school district or nonpublic school and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to also work with the school in establishing a plan for use and storage of backup medication if prescribed, as above, by my child's physician. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma or anaphylaxis emergency.

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the physician may rewrite the order on his prescription pad and I, the parent/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and the medication that is not picked up will be disposed of.

Parent/Guardian, Caretaker Relative Signature: _____ Date: _____

(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)