CAMPBELL UNION HIGH SCHOOL DISTRICT

Authorization for Student to Carry Medication in School

TO BE COMPLETED BY PHYSICIAN

Date:_________

I certify that ____, D.O.B. ____________,
(Student's Name)

must carry ____ with him/her at all
(Name of Medication)

times at school due to ____.
(Medical Condition)

This condition is such that there is inadequate time for the student to go to the office to obtain the medication. I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than himself/herself. I have discussed the above stated risks and liabilities with the parent.

_____________________________________ _________________
Physician's Signature Date

_____________________________________ _________________
Physician's Name Phone

TO BE COMPLETED BY PARENT/GUARDIAN

I permit my child to carry the above listed medication as ordered/approved by his/her physician. I have fully instructed my child on the proper administration of this medication and certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication and certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication by my child. I am aware of the risks to my child and other children and assume responsibility for any liability related to the misuse of this medication by my child or by other children.

_____________________________________ _________________
Parent Signature Date

_____________________________________ _________________
Home Phone Work Phone

(OVER)