

Authorization For Students to Carry Emergency Medication

administer their own emergency i	medication, in which school p	personnel are authorized to administer.
prescribed by their physician (inflemergency seizure medication a	naler, epinephrine auto inject	
The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication if able.		
		hrine auto injector, insulin, diabetic nergency prescribed medication be
Name of Medication:		
Practice Name	Address	Telephone Number
Physician's Name (Please Print)	Cre	edentials
Physician's Signature		Date
how it is administered. I will not a I also understand that should and	llow another student to use no other student use my prescrip	peled medication and fully understand ny medication under any circumstances. ption, the privilege of carrying my fying the school nurse each time I take
Student's Signature		Date
I hereby request that the above- carry, and use this prescribed m		have legal guardianship, be allowed to
person other than the abo	ove-named student.	ost, given to, or taken by another carrying the medication may be altered.

FCS acknowledges that a student who carries their emergency medication may not be able to self-

Parent/Guardian Name (Please Print)

Parent/Guardian Signature

• I release Forsyth County School System and its employees of any legal responsibility when

the above-named student administers his/her own medication.

Date

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Revised: January 2024