Bastrop
Independent School District

AUTHORIZATION FOR SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION ON CAMPUS AND DURING AFTER-SCHOOL ACTIVITIES

Bastrop ISD permits a responsible, trained student to carry and self-administer emergency medications for immediate use in a life-threatening situation or for enzymes used in Cystic Fibrosis. A written order from a physician with parent, school nurse and principal signatures is required each school year. In situations where a student is unable to self-administer their emergency medication a safe carry, administration and storage plan must be in place.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER AUTHORIZATION

Name of Student: _____ DOB: _____ Grade: _____

Condition for which the medication is administered: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: _____

Side effects to be noted/reported:

_____

Other recommendations: _____

Duration (dates) of administration: From _____ To _____ (Limit of one school year)

IN MY OPINION, THIS STUDENT DEMONSTRATES THE ABILITY TO:

☐ **SELF-CARRY THE ABOVE MEDICATION ONLY** ☐ **SELF-CARRY & SELF ADMINISTER THE ABOVE MEDICATION**

_____	_____	_____	_____
Physician Signature	**Print Name**	**Phone**	**Date**

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry/self-administer the above ordered medication. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing physician and medication, dose of medication and directions for use. It must be a current prescription and medication must not be expired.

**Please initial next to the ONE self-carry method that applies to your child.*

_____ **Self-Carry/Self Administer ONLY**: I understand that my child will be held responsible for the possession and control of the medication during the time he/she is under the school's jurisdiction. I understand that this medication may not be distributed by my child to anyone else and that I may be held liable if my child does distribute this medication to anyone else. I understand that BISD cannot be held liable for any misuse/abuse of the medication by my child. Therefore, I release Bastrop ISD from any responsibility for my child's actions with regard to the prescribed medication. Furthermore, I realize that any misuse/abuse of the medication by my child may result in disciplinary action by the Bastrop ISD. ***My child rides the bus: [ ] yes [ ] no**

_____ **Self-Carry ONLY:** I understand that it is my responsibility to provide a safe and secure method for this medication to be carried and stored with my child. I understand that it is my responsibility to inform the appropriate school staff that the medication is with my student and where it is being stored. ***My child rides the bus: [ ] yes [ ] no**

_____	_____	_____	_____
Parent/Guardian Signature	Date	Student Signature	Date

_____	_____
Parent/Guardian Telephone Number	Campus Student Attends

DISTRICT APPROVAL

We accept the above physician/prescribing health care provider and parent/guardian authorizations. We reserve the right to withdraw this privilege if the student shows signs of irresponsible behavior or misuse of this medication.

_____	_____	_____	_____
Campus Nurse Signature	Date	Principal Signature	Date

EMS will be called anytime an emergency medication is administered

Bastrop
Independent School District

AUTORIZACIÓN PARA EL USO O AUTOADMINISTRACIÓN DE MEDICAMENTOS DE EMERGENCIA EN EL CAMPUS Y DURANTE LAS ACTIVIDADES DESPUÉS DE LA ESCUELA

Bastrop ISD permite que un estudiante responsable y capacitado lleve consigo y se autoadministre medicamentos de emergencia para el uso inmediato en una situación que amenaza la vida o para enzimas utilizadas en la fibrosis quística. Cada año escolar se requiere una orden escrita de un médico con las firmas de los padres, la enfermera escolar y el director. En situaciones en las que un estudiante no puede autoadministrarse su medicamento de emergencia, se debe implementar un plan de transporte, administración y almacenamiento seguro.

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER AUTHORIZATION

Name of Student: _____ DOB: _____ Grade: _____

Condition for which the medication is administered: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: _____

Side effects to be noted/reported: _____

Other recommendations: _____

Duration (dates) of administration: From _____ To _____ (Limit of one school year)

IN MY OPINION, THIS STUDENT DEMONSTRATES THE ABILITY TO:

⬜ **SELF-CARRY THE ABOVE MEDICATION ONLY** ⬜ **SELF-CARRY & SELF ADMINISTER THE ABOVE MEDICATION**

_____	_____	_____	_____
Physician Signature	**Print Name**	**Phone**	**Date**

AUTORIZACIÓN DE PADRE/TUTOR

Solicito que a mi hijo, mencionado anteriormente, se le permita llevar/autoadministrarse el medicamento indicado. Entiendo que el medicamento debe estar en el envase original de la farmacia, etiquetado con el nombre del estudiante, médico que lo receta, dosis del medicamento e instrucciones de uso. Debe ser receta vigente y el medicamento no debe estar caducado.

*Por favor ponga sus iniciales junto a UN método de administración que se aplique a su hijo.

_____ **Autotransporte/Autoadministración SOLAMENTE:** Entiendo que mi hijo será responsable de la posesión y control del medicamento durante el tiempo que esté bajo la jurisdicción de la escuela. Entiendo que mi hijo no puede distribuir este medicamento a nadie más y que puede ser considerado responsable si mi hijo distribuye este medicamento a otra persona. Entiendo que BISD no se hace responsable del mal uso o abuso de este medicamento por parte de mi hijo. Por lo tanto, libero a Bastrop ISD de cualquier responsabilidad por las acciones de mi hijo con respecto al medicamento recetado. Además, comprendo que cualquier mal uso/abuso del medicamento por parte de mi hijo puede resultar en una acción disciplinaria por parte de Bastrop ISD. ***mi hija monta el autobus [ ]si [ ] no**

_____ **Autotransporte SOLAMENTE:** Entiendo que es mi responsabilidad proporcionar un método seguro para llevar y almacenar este medicamento con mi hijo. Entiendo que es mi responsabilidad informar al personal escolar apropiado que el medicamento está con mi estudiante y dónde está almacenado. ***mi hija monta el autobus [ ] si [ ] no**

_____	_____	_____	_____
Firma del padre/tutor	Fecha	Firma del estudiante	Fecha

_____	_____
Número de teléfono del padre/tutor	Escuela a la que asiste el estudiante

APROBACIÓN DEL DISTRITO

Aceptamos las autorizaciones del médico/proveedor de atención médica que prescribe y de los padres/tutores mencionados anteriormente. Nos reservamos el derecho de retirar este privilegio si el estudiante muestra signos de comportamiento irresponsable o mal uso de este medicamento.

_____	_____	_____	_____
Campus Nurse Signature	Date	Principal Signature	Date

Se llamará a EMS cada vez que se administre un medicamento de emergencia