AUTHORIZATION FOR STUDENTS TO CARRY MEDICATION  

Date: 05/22/2014

As provided for in Douglas County Board of Education Policy JGCD and Regulation JGCD-R, ____________________________, ________________________________ needs to carry the following labeled medication with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage and Directions</th>
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Physician’s Signature

I have been instructed in the proper use of my labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my medication, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school health monitor to keep her informed of use of my medication in case I start having problems.

Student’s Signature

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Douglas County School system and its employees of any legal responsibility when the above named student administers his/her own medication.

I authorize exchange of information/communication between the prescribing physician and Douglas County School System Health Services Coordinators regarding any prescription medication(s).

Parent/Guardian Signature

Reviewed by School Nurse

School Administrator’s Signature