

Exhibit 507.02E3-E(1): Parental Authorization and Release Form for the Independent Self Carry and Administration of Prescribed Medication or Independent Delivery of Health Services by the Student - Parental Authorization and Release Form for Independent Self Carry and Administration of Prescribed Medication of Independent Delivery of Health Services by the Student

Status: ADOPTED

Original Adopted Date: 08/28/2023 | **Last Reviewed Date:** 08/28/2023

See PDF on the next page.

PARENTAL AUTHORIZATION AND RELEASE FORM FOR INDEPENDENT SELF CARRY AND
ADMINISTRATION OF PRESCRIBED MEDICATION OF INDEPENDENT DELIVERY OF HEALTH
SERVICES BY THE STUDENT

____ / ____ / ____
Student's Name (Last), (First), (Middle)

____ / ____ / ____
Birthday

____ / ____ / ____
School

____ / ____ / ____
Date

I request the above-named student (Parent/Guardian initial all that apply)

Carry and complete co-administration of prescribed medication, when competency has been demonstrated to licensed health personnel working under the auspices of the school. In accordance with applicable laws, students with asthma, airway constricting diseases, respiratory distress or students at risk of anaphylaxis who use epinephrine auto-injectors may self-administer their medication upon the written approval of the student's parents and prescribing licensed health care professional regardless of competency. The information provided by the parent for medication administration is confidential as provided by the Family Education Rights and Privacy Act (FERPA) and any other applicable laws. I agree to provide safe delivery of the medication to and from school and to pick up remaining medication at the end of the school year or when medication is expired. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed, after notification is provided to the student's parent.

Prescribed Medication	Dosage	Route	Time at School
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Co-administer, participate in planning, management and implementation of special health services at school and school activities after demonstration of proficiency to licensed health personnel working under the auspices of the school. The information provided by the parent for health service delivery is confidential as provided by the Family Education Rights and Privacy Act (FERPA) and any other applicable laws. I agree to coordinate and work with school personnel and the prescriber (if indicated) when questions arise. I agree to provide safe delivery of the student's equipment necessary for health service delivery to and from school and to pick up remaining equipment at the end of the school year.

Special Health Services Delivery:

Procedures for abandoned medication disposal shall be in accordance with applicable laws.

Prescriber's Signature

____ / ____ / ____
Date

and credentials (when indicated for health service delivery)

Parent/Guardian Signature

Date

Parent/Guardian address

Home phone