

**OCEAN SPRINGS SCHOOL DISTRICT
PHYSICIAN AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA, ANAPHYLAXIS OR DIABETES
MEDICATION BY STUDENTS IN THE OCEAN SPRINGS SCHOOL DISTRICT.**

Use a separate authorization from for each medication

Date: _____ Student's Name: (First/Last) _____

School: _____ Student's Date of Birth: _____

TO BE COMPLETED BY STUDENT'S LICENSED HEALTH CARE PROVIDER:

Diagnosis: _____

Medication Name: _____

Medication Dose: _____

Medication Time to be Given: _____

Length of Time Medication is to be Given: _____

Additional Medication Information: _____

() I, the student's health care provider, have instructed _____ on the proper way to use the above medication. He/She possess the knowledge and are capable of self administration of the above medication. It is my professional opinion that he/she should be allowed to self carry and self-administer the above medication.

() It is my professional opinion that _____ should NOT be allowed to self carry or self-administer the above medication by him/herself.

Comments: _____

Licensed Health Care Provider Signature

Date

Licensed Health Care Provider Phone Number

OCEAN SPRINGS SCHOOL DISTRICT
PARENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA, ANAPHYLAXIS OR DIABETES
MEDICATIONS BY STUDENTS IN THE OCEAN SPRINGS SCHOOL DISTRICT.

I/We, the undersigned parent/s or guardian/s of _____, authorizes the school/school district to permit my/our child to self-administer asthma, anaphylaxis or diabetes medication. I/We understand that a written statement must accompany this authorization from my/our child's health care practitioner verifying the following:

1. The student has asthma, diabetes, or an allergy that is at risk for anaphylaxis.
2. The student has been instructed in self administration of asthma, anaphylaxis or diabetes medication.
3. The student possess the knowledge and capability of self-administering the asthma, anaphylaxis or diabetes medication.
4. Exhibit JGCD-E(1) Ocean Springs School District Medication Permission Request Form completed by both the student's parent/s or guardian/s and the student's health care practitioner. Exhibit JGCD-E(1) Shall contain the following information:
 - a. The name and purpose of the medication;
 - b. The prescribed dosage;
 - c. The time or times the medication are to be administered and under what additional special circumstances the medication are to be administered; and
 - d. The length of time for which the medication is prescribed.

RELEASE AND INDEMNITY AGREEMENT

I/We forever release, discharge, and covenant to hold harmless the Ocean Springs School District, its personnel and Board of Trustees from any and all claims, demands, damages, expenses, loss of services and causes of action belonging to my/our child or the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from self administration of the asthma, anaphylaxis or diabetes medicines.

I/We agree to repay the school district, its personnel or trustees any sum or money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury to my/our child as a result of self administration of the asthma, anaphylaxis or diabetes medicines.

I/We understand that any child may be subjected to discipline in accordance with other district policies for misuse of any asthma, anaphylaxis or diabetes medication, distribution or sale of any asthma, anaphylaxis or diabetes medication, allowing another student to use any asthma, anaphylaxis or diabetes medication, or use of any asthma, anaphylaxis or diabetes medication in any manner not prescribed by the student's health care practitioner.

I/We have read the foregoing release and indemnity agreement and fully understand it.

Executed this the _____ day of _____, 20__.

Parent or Guardian Signature

Witness Signature

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Contact Person Other Than Parent: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____