Dripping Springs
INDEPENDENT SCHOOL DISTRICT

AUTHORIZATION FOR SELF-CARRY/ ADMINISTRATION OF MEDICINE AT SCHOOL
for students with asthma, life-threatening allergies, & type 1 diabetes

DSISD permits a responsible, trained student to carry and/or self -administer medication as indicated for asthma, severe allergic reaction (anaphylaxis), and type 1 diabetes on their person for immediate use in a life-threatening situation with a written order from the attending physician, request from their parent/guardian, and approval of the school nurse in accordance with Texas Education Code (TEC) Ch 38.0015 and Texas' Health and Safety Code (THSC) Ch 168.008.

To Be Completed by Physician / Prescribing Healthcare Provider:

Student Name:	Date of Birth:
Medication:	Dosage/Route:
Diagnosis:	Indication(s):
IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.	
Physician signature:	**Date:**
Physician Name (please print):	Phone:
Authorization valid from (please check): ______ Date form received ***Limit of 1 school year** ______ Other: _______________	End: _____ End of school year _____ Other:________________

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to: ____carry _____self-administer the above ordered medication. I take responsibility for this permission and I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, name of medication, dosage, and directions for use. I understand that the school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. In the event of this behavior, I will be contacted by the nurse as soon as possible.

_______________________________________ _______________________________________

Parent Signature Date Student Signature Date