



Name: _____

DOB: _____

School: _____

Grade: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self- administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Self-Carry

Self-Administer

Healthcare Provider Signature

Print Healthcare Provider Name

Date

Parent/Guardian Response

In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student’s possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

Parent/Guardian Signature

Date

Student Signature

Date

Permission to Carry and/ or Self-Administer Epinephrine (if appropriate)

JHCF-R2 (Form3)

New Kent County Public Schools
