SANTA CRUZ VALLEY
Unified School District No. 35
Educate Everyone Every Day

Santa Cruz Valley Unified School District #35

Parent Authorization for **Approved** Self Carry Medication(s)

School _____ Year _____/_____

Student's Name_____ DOB _____

Student's ID# _____ Grade _____

TO BE COMPLETED BY PARENT/GUARDIAN (Circle)

Mother's Name: _____ Father's Name _____

Mother's Contact _____ Father's Contact _____

Mother's Work # _____ Father's Work # _____

Emergency Contact #'s _____

Physician Name _____ Physician # _____

I give permission for my child to self-carry and administer _____.

(Name of Medication)

My child has been instructed on proper use of this medication and has been informed that sharing or giving this medication(s) to another student will result in possible disciplinary action and possible revocation of this privilege.

Medication must be clearly labeled with name of medication and student's name.

Parent/Guardian Signature: _____ Date: _____

Comment _____

*Approved Self Carry Meds are: Inhaler & EpiPens. Other medications may require a Physician order to accompany this form.

Revise 11/19/2019