Pittsburgh Public Schools | EXCELLENCE FOR ALL

# PITTSBURGH PUBLIC SCHOOLS

**Rescue Medication Access Permission Form**

**2014 - 2015 School Year**

Rev. 7/2011

There are several medications that are designated as Rescue Medications: Albuterol, Insulin pens, fast acting glucose, and epinephrine injection pens. These may be carried by a student and self-administered if the student is mature enough for the responsibility and the criteria listed below are met.

1. The student's parent/guardian submits a completed Rescue Medication Permission Form for the current school year, including student, parent/guardian, and physician signature.
2. The student's parent/guardian provides a completed Administration of Medication Form.
3. The rescue medication is contained in the original container and appropriately labeled.
4. The School Nurse agrees that the student is capable of identifying when the rescue medication is required and how to use the medication appropriately.
5. Furthermore, the student agrees that:
   - Under NO circumstances will he/she SHARE the rescue medication, or involve another student in the self administration of that medication.
   - He/She will use the rescue medication only as prescribed.
   - He/She will notify the school nurse if the medication is self-administered.
6. The parent/guardian agrees to accept full liability for injuries secondary to inappropriate use of the medications by the student.
7. The parent/guardian agrees to notify the school immediately of any medication changes.
8. The parent/guardian understands that the Board of Education has the right to deny and /or revoke this privilege if the student fails to demonstrate that he/she is responsible and mature enough to carry and/or use their medication.

**SCHOOL YEAR: 2014 - 2015**

| | | | | |
|---|---|---|---|---|
| **PRINT NAME OF STUDENT** | | **SCHOOL** | | **GR.** |
| **PRINT NAME OF PARENT/GUARDIAN** | | **PHONE** | | |
| | | **ALT. PHONE** | | |

**I AGREE TO THE CONDITIONS ABOVE**

| | | | |
|---|---|---|---|
| ✘ | | ✘ | |
| **Signature - Student** | **Date** | **Signature - Parent/Guardian** | **Date** |

**MEDICAL PROVIDER: The above named student is capable of self administering the medication listed below.**

| | | | |
|---|---|---|---|
| **Medical Condition:** | | **Medication:** | |
| **Dose & Time(s):** | | | |

| | | | |
|---|---|---|---|
| ✘ | | ✘ | |
| **Provider's Signature** | | **Print Provider's Name** | **Date** |

| | | |
|---|---|---|
| **Phone:** | **Alt Phone:** | **Fax:** |

| | | |
|---|---|---|
| **SCHOOL NURSE:** **Student demonstrates appropriate ability to self administer above medication.** | **Yes** ☐ | |
| | **No** ☐ | |

| | | |
|---|---|---|
| ✘ | ✘ | |
| **School Nurse's Signature** | **Print Name** | **Date** |