Pittsburgh Public Schools
Expect great things.

PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES

Rev. 7/2018

RESCUE MEDICATION ACCESS PERMISSION FORM

There are several medications that are designated as Rescue Medications: Albuterol, 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 is met.

1. The parent/guardian submits the completed "Rescue Medication Access Permission Form" for the current school year.
2. The parent/guardian also submits the completed "Consent for Administration of Medication and Medication Order Form for the current school year.
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 after the student demonstrates appropriate ability to self-administer the named medication.
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 must 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 nurse immediately of any medication changes.
8. The parent/guardian understands that the Pittsburgh Public Schools 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.

ENTER SCHOOL YEAR: _____

PRINT NAME OF STUDENT	SCHOOL	GR.
PRINT NAME OF PARENT/GUARDIAN	BEST PHONE	
	ALT. PHONE	

I AGREE TO THE CONDITIONS ABOVE

x		x	
SIGNATURE - STUDENT	DATE	SIGNATURE - PARENT/GUARDIAN	DATE

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

MEDICAL CONDITION:	MEDICATION:
DOSE & TIME(s):	

x		x	
PROVIDER'S SIGNATURE		PRINT PROVIDER'S NAME	DATE

PHONE:	ALT PHONE:	FAX:

SCHOOL NURSE: STUDENT DEMONSTRATES APPROPRIATE ABILITY TO SELF-ADMINISTER THE NAMED MEDICATION.	YES ☐
	NO ☐

x		x	
SCHOOL NURSE'S SIGNATURE		PRINT NAME	DATE