

WELLNESS AND HEALTH SERVICES  
MEDICAL TREATMENT

EXHIBIT C

MIDLAND INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT  
AUTHORIZATION FOR SELF CARRY AND SELF ADMINISTRATION OF  
ANAPHYLAXIS MEDICATION

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Homeroom Teacher: \_\_\_\_\_ Grade/Student ID#: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
PRINT Parent /Guardian First and Last Name

\_\_\_\_\_  
Parent/Guardian Signature

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Physician Please Check:

\_\_\_\_\_ It is my professional opinion that \_\_\_\_\_ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_  
When to use: \_\_\_\_\_

How often can medication be repeated? \_\_\_\_\_ At what interval? \_\_\_\_\_

Additional instructions:  
\_\_\_\_\_

Physician Signature:  
\_\_\_\_\_

Print Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Office #: \_\_\_\_\_ Fax #: \_\_\_\_\_