MEDICATION SELF-ADMINISTRATION
OUTSIDE SCHOOL HOURS, ON SCHOOL GROUNDS OR AT SCHOOL ACTIVITIES
POLICY JGCD-E (3)

When possible, medications should be given to students before or after school hours by the parent or guardian. Medications must be in the originally labeled container. No more than two doses should be in the container.
Please, complete a separate form for each medication to be self-administered.

Student Name:		Date of Birth:
School:	Grade:	Teacher:

Is your student allergic to any food, medicine, or other items? ☐ No ☐ Yes (if yes, list allergies)

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication to be taken: If possible, specify preferred time. ☐ To be taken only as needed per container/package directions	Period of time medication to be given: ☐ Until the end of school year ☐ _____school days ☐ _____ weeks
Possible side effects:	

Health Care Provider's Signature Required For All Self-Administration Medications	
Prescribing Health Care Provider's Signature:	Date:
Stamp, Print, or Type Health Care Provider's Name & Address	Office Phone Number Office Fax Number

I give permission for the above student to keep the above medication with him/her during the school day for use after school hours on school grounds or at school sponsored activities. My student understands the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. My student also understands that this medication is not to be distributed to any other student or district employee. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about self-administration of medications before self-administration of this medication will allowed at school. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent/Guardian	Print or Type Name of Parent/Guardian	Date
Signature of Student	Print or Type Name of Student	Date

FOR SCHOOL USE ONLY Approved: _____ Principal or School Designee Date: _____

Revised May 2009