MEDICATION ADMINISTRATION PERMISSION

Self-Administration (Emergency Medications)

POLICY JGCD-E (2)

When possible, medications should be given to students before or after school hours by the parent or guardian. Medications must be provided to the school in the originally labeled container. Medications may only be given within the limits of the prescribing health care provider's order and/or instructions printed on the container or package insert. ***Please, complete a separate form for each medication to be given at school.***

Student Name:		***Date of Birth:***
School:	***Grade:***	***Teacher:***
Does the student have any allergies? ☐ *Yes* ☐ *No (If yes, please list allergies.)*		

This section MUST be completed by the prescribing physician/practitioner for all medications to be self-administered or kept on the student at school. (SDPC policy allows for self-administration of emergency medications only.)		
Medication:		**Dosage:**
Purpose of Medication:	**ICD-10 Code:**	**Route:**
Time of day medication to be given at school: *(If to be given at lunch, state "lunch" since lunch times vary.)*	**Period of time medication to be given:** ☐ _____ weeks ☐ _____ days ☐ Until the end of the school year ☐ Other (please specify date) _____	
Possible side effects:		

I, as prescribing physician, give permission for the above student to keep the above medication with him/her during the school day, after school activities, and school sponsored activities off campus. The student and parent/guardian understands the circumstances warranting administration of this medication and the student is responsible enough to keep it with him/her and to administer it to himself/herself.

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, after school activities, and school sponsored activities off campus. The parent/guardian and student understand the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. The parent/guardian and student also understand 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 pharmacist and/or their 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 Name of Parent/Guardian***	***Date***
Signature of Student	***Print Name of Student***	***Date***

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