USD 384
Blue Valley/Randolph
Permission for Self-Administered Medication
Inhaler, Epi-Pen, Insulin, only

Student Name_____ Grade _____

Medication _____ Reason _____

Dosage _____ Time _____

Possible Side Effects _____

Date Medication started _____

_____Student is both capable and responsible for carrying and self-administering this medication as prescribed.

Signature of Prescriber_____ Date _____

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I am the lawful custodian of_____. I give my permission for him/her to take the above prescribed medication while at school. I certify that one does of this medication has been given and my child did not suffer any adverse reactions. I understand that it is my responsibility to furnish this medication. I also understand that any designated school employee who assists with administering this medication to my child in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse reactions suffered by my child due to to mislabeled or altered product. I hereby authorize USD #384 School Nurse to exchange information regarding this request with the health care provider and/or the pharmacist as necessary.

Signature of Parent_____ Date_____

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_____I accept the responsibility of carrying and administering my own Inhaler, Epi-pen, or Insulin.

This means I will: _____ Have this medication with me at all times.
_____ Follow the doctor's orders for taking and/or using this medication
_____ Not allow other students to use my medication
_____ Label my medication with my full name and name of medication.

Signature of Student_____ Date_____

Note: The school district medication policy complies with state regulations. Self-Administration Medication DOES NOT include Over-the-Counter Medications or other prescription medications such as Ritalin, Adderal, Antibiotics, etc. Self-Administration Medication Forms are to be kept on file in School Office and must be renewed at the beginning of each school year. *updated 2016*