RECORD OF SELF-ADMINISTERED MEDICINE

Parent's Phone_____

Student Name_____ Grade _____

Date to Begin _____ Date to End _____

Name of Medication _____

Dosage of Medication _____ Time _____

Doctor_____ Phone #1_____

Phone #_____

Possible Adverse Reaction:_____

_____ gives permission for _____ our son/daughter to self-administer specific medications at school. This medication cannot be taken at any other non-school time.

DATED this _____day of_____. 20___.

Students who are able to self-administer specific medication may do so provided:

1. The physician provides written authorization allowing self-administration of said medication.
2. The parent provides written authorization allowing self-administration of said medication.
3. Such medication is transported to the school and maintained under the student's control in the original, properly labeled package and (a) is not opened except when self-administering the medication, (b) is not self-administered during instructional time or in the presence of other students unless medically necessary, and (c) is not shown or exhibited to other students.
4. The student's physician or physicians' designee has (1) evaluated the situation and deemed it to be safe and appropriate; (2) documented this on the physician's authorization for the student's cumulative health record, and (3) approved the general administration plan.
5. The student and the student's physician or physician's designee have developed a plan for reporting and supervising self-administration.
6. The principal and appropriate teacher are informed that the student is self-administering prescribed medication.

Doctor's Signature _____