PARSONS DISTRICT SCHOOLS
Home of the Vikings

Parsons Vikings

Authorization for Self-Administration/Carry of Medication

Parent/Legal Guardian to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

Prescribing Physician Name: _____ Phone Number: _____

Medical Reason: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. **I acknowledge that the school district and it officers', employees or agents incurs no liability for any damage, injury or death resulting directly or indirectly from self-administration of medication and agree to release, indemnify and hold the school, and its officers, employees and agents, harmless against any claims relating to the self-administration of such medication.**

I also acknowledge the need and give permission for appropriate communication between the school health professional and the medical prescriber related to the specific treatment in questions, including communication concerning: 1. The prescription or treatment itself (e.g. questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. Implementation of the treatment in school (e.g. questions regarding safety concerns, infection control issues, or medications in the treatment order related to the school setting or students' academic schedule); 3. Student outcomes from treatment (e.g. questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. And other pertinent issues related to the student's diagnosis, condition, or treatment.

_____	_____	_____
Parent/Legal Guardian Signature	Parent/Legal Guardian (Printed Name)	Date

Physician to Complete

Medication	**Purpose**	**Dosage**	**Time/Frequency**
_____	_____	_____	_____
_____	_____	_____	_____

Conditions & Special Circumstances for use: _____

Length of time medication is to be administered: _____

_____	_____	_____
Physician Signature	Physician (Printed Name)	Date

School Nurse to Complete

School Nurse Review of order and procedure with the student. Completed: _____ _____

Date of Review Initials