

AUTHORIZATION FOR SELF-ADMINISTERED MEDICATION

Prescription Medication

PHYSICIAN/LICENSED HEALTH CARE PROVIDER STATEMENT

The student _____ has
_____ asthma _____ anaphylaxis _____ diabetes
_____ other _____

and is capable of self-administering the following prescription medicine at school:

Medication: _____

Dose: _____

Times/Circumstances to Administer: _____

Reason child is taking medication: _____

Precautions and reactions to observe and report: _____

Signature of Physician/Other Licensed Health Care Provider _____

Date: _____

Over-The-Counter Medication

(Middle School and High School)

The student _____ has permission and is capable of self-administering the following over-the-counter medicine:

Medication: _____

Dose: _____

Times/Circumstances to Administer: _____

Reason child is taking medication: _____

*****Students may only bring a one-day supply of medication. Students are prohibited from transferring, delivering or receiving medications to or from other students.**

PARENTAL AUTHORIZATION

1. I am the parent/guardian of _____ and I authorize my child/ward to self-administer the medication identified above while on school property or at a school-related event or activity.
2. I release the school and its employees and agents from liability for injury arising from the student's self-administration of the medication while on school property or at a school-related event.
3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the student's immediate access to the medication.
4. I authorize the school nurse to inform appropriate school employees who would have a need to know that the student may self-administer medication.
5. I give permission for the student to have the prescription medication with the student while on school property or at a school-related activity or event.

Signature of Parent/Guardian _____ Date _____

(See reverse side for consent for over-the-counter medication administration)

Consent for Over-the-Counter Medication Administration

1. I, _____, am the parent or guardian of _____, and I authorize my child/ward to be administered the over-the-counter medication identified below while on school property or at a school-related event or activity by the school nurse or employee trained in the administration of medication.
2. I hereby release the District and its employees and agents from liability for injury arising from the school's administration of the medication while on school property or at a school-related event.
3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school. However, any disciplinary action may not limit or restrict the student's immediate access to the medication.
4. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers).
5. I acknowledge and agree that the school shall secure (store) the medication for the student until the administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker.
6. I acknowledge that the medication must be brought to school by an adult in the original bottle or package.

Medication _____

Dose _____

Time _____

Authorized Start Date _____ End Date _____

Signature of Parent/Guardian _____ Date _____