USD 378

Riley County Schools

Permission for Self-Administration of
Anaphylaxis or Asthma Medication, Insulin

Name of Student_____ Grade_____

Medication_____ Purpose_____

Dosage_____ Time_____

Conditions &Special circumstances for use_____

Possible Side Effects_____

Length of time medication is be administered_____

_____ _____
Physician's Signature Date

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My child_____ has been instructed on self-administration of the medication named and has my permission to administer the above named medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school and it employees and agents harmless against any claims relating to the self-administration of such medication.

_____ _____
Parent/Guardian Signature Date

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I accept the responsibility of carrying and administering my own (mark correct medication)

___Inhaler ___Epi-pen ___Insulin

This means I will: _____Have the medication with me at all times

_____Follow the doctor's orders for taking and/or using this medication

_____Not allow anyone else 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, Adderall, 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 medication is needed. *Update 3/2023*