Authorization for Self-Administered Medication

Student's Name: ______________________________ Grade: ______ DOB: ____________

Parent/Guardian Name: ____

Telephone: (Home): ________________________ (Work): __________________________

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

____ ____________________

Parent/Guardian's Signature Date

……………………………………………………………………………………………..…………

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

I am recommending that the above named student be allowed to self-administer the following medication.

Name and Purpose of Medication: ____

Identification of Chronic Medical Problem: ____

____

Prescribed Dosage to be Taken: ____

Length of Time Medication Must be Taken: ____

Possible Side-Effects and/or Special Precautions to be Taken: __________________________

____

Conditions Under Which Self-Medication Will Take Place:

_____ **Independently** (*Child must have had training and be proficient in self-administering medication.*)
Trainer's Name: ____

Date of Training: ____________________

_____ **Under the supervision of a school nurse**

Medication should be: _____ Stored in the Health Office

_____ In the possession of the student

____________________________________ ____________________________________
Type or Print Physician's Name Physician's Signature

____
Date

Policy History:
Adopted on: October 13, 2014
Revised on: