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