REQUEST AND AUTHORIZATION
FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student_____ Date _____

Grade_____ Date of Birth_____ School _____

Allergies_____ School Year_____

PHYSICIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION OR OVER THE COUNTER

Medication_____ Dose_____ Route_____
Time /Frequency_____ Continue Until_____

I have reviewed the medication with the student and the student's parents, and the medication may be self- administered by the student during school hours.

Date_____ Physician Name (Print) _____
Physician Signature _____
Phone_____ Address_____

The student is capable of self administering this medication in a secure manner No Yes supervised Yes unsupervised
This student may carry this medication Yes No (kept in Nurse Office)

The undersigned, as parent(s)/guardian of the above named student, request permission for, and hereby authorize, the student to self-administer the above named medication during school hours. Further, the undersigned acknowledge and understand the following:

1. Medication shall be maintained in the original prescription container with original label;
2. School personnel may examine the medication container upon request, and any medications not maintained in the original container may be confiscated by school personnel;
3. The school may require the student to store the medication in a central location in the school;
4. The undersigned has reviewed the medication administration procedure with the student and believe student understands the administration procedure and is capable of self-administering the above medication;
5. The undersigned will notify the school immediately if the student's health status changes, or there is a change or cancellation of this medication;
6. School employees and personnel will not be involved in the administration of the above medication and will not be monitoring the student for side effects or student's failure to take the medication. The undersigned and student shall be solely responsible to assure that the medication is taken as prescribed.
7. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.
8. This student has received instruction in self administering the medication in a secure manner. In addition, the student has received education on any side effects or adverse interactions associated with the medication and how to prevent them.
9. For any controlled medication that the student will self administers only 2 or 3 pills can be in their possession at one time.

In consideration of this authorization, given at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees of the School and Board of Education from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Date_____ Parent/Guardian_____

Phone (H)_____ Address_____

(W)_____ (C)_____