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)_____

PRESCRIPTION OR OVER THE COUNTER (OTC) AUTHORIZATION FOR MEDICATION ADMINISTRATION

When it is determined by the physician that medication must be taken during the school hours this form is to be completed.

Student_____ Date_____

Grade_____ Date of Birth_____ School_____

Allergies_____ School Year_____

PHYSICIAN'S ORDER or Clinic to provide a current computerized medication list to the school.

Medication_____ Dose_____ Route_____

Time /Frequency_____ Continue Until_____

Reason for Medication/Diagnosis_____

Special Instructions_____

Major Side Effects/Reactions_____

Action/treatment for side effects_____

Special handling instructions Refrigeration Keep out of sunlight Other_____

Date_____ Physician Name (Print)_____

Physician Signature*_____

Phone_____ Address_____

*Physician signature on OTC medications is required only if dosage is not within the manufacturer's recommended guidelines.

Amount of Medication Received_____ Medication Expiration Date_____

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. 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. In consideration of this authorization made 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 involved in the administration of medications to the above named student 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. Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization. I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's health record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

Date_____ Parent /Guardian_____

Phone (H)_____ Address_____

(C)_____ (W)_____

Alternate family member's emergency contact name and number_____

_____ Home Work Cell