SCHOOL HEALTH SERVICES

PRESCRIPTION MEDICATION SELF-ADMINISTRATION CONSENT FORM (PHYSICIAN'S SIGNATURE REQUIRED)

Requires renewal at the beginning of each school year

Name of Student		D.O.B.	
Address		Telephone	
Parent/Guardian Name		School	
Diagnosis			
Name of medication/treatment			
Dose			
Time(s) to be administered at school			
Method (route) of administration			
Medication to be administered from		to	
	Month/Day/Year		Month/Day/Year
Precautions and reactions to observe and repo	ort		

GRADES 6-12

I CERTIFY THAT THE ABOVE NAMED STUDENT IS CAPABLE OF SELF-ADMINISTRATION OF THE ABOVE PRESCRIBED MEDICATION.

Physician's Signature

Telephone

Date

PRINT Physician's Name

Clinic Name

(Changes may be called to the e<u>School Nurse</u> by the prescribing provider with written confirmation following within 24 hours. Faxes are acceptable.)

I authorize my child to self-administer the above medication while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider and the school nurse to insure safe medication administration.

Parent/Guardian Signature _____ Date _____

Students are prohibited from transferring, delivering or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.