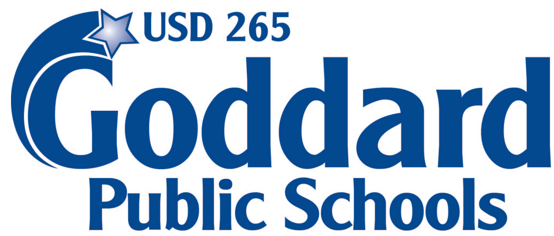


PERMISSION FOR SELF ADMINISTERING OF MEDICATION

For Students Grades K –12

Name of Student___________________________________ Grade_____________

School____ Age_______________

Name of Medication____

Dosage____

I hereby give permission for _____________________ to self administer the above medication at school. I understand it is my responsibility to furnish this medication in the original container. I acknowledge that the school incurs no liability for any injury resulting from the self administering of the medication and I hold the school, and its employees and agents, harmless against any claims relating to the self administering of such medication.

CONDITIONS OF PERMIT TO CARRY:

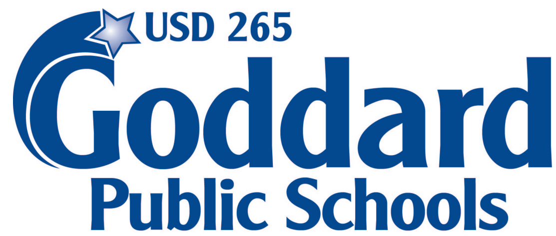
1. Over the counter medications, such as antacids, cough drops, pain relievers, etc. may be carried according to this permit.
2. All medications prescribed by your physician ***MUST*** have a school district medication policy form signed by said physician in addition to this form.
3. Pharmacy labels are not a substitute for a physician signature. Pharmacy labels must contain an expiration date.
4. Medications such as narcotics, psychotics, and some other prescriptions may not be kept by students.
5. Student will also need to meet requirements of the ***nursing assessment*** located on the back of this form. (*Assessment to be completed by school nurse.*)
6. Any abuse of the self administration plan will result in the loss of privilege.

MY CHILD HAS BEEN INSTRUCTED ON SELF ADMINISTERING OF THE MEDICATION AND IS AUTHORIZED TO DO SO IN SCHOOL.

Signature Of Parent/Guardian ____

Date____________

Revised 6/8/2015



THIS FORM MUST BE RESUBMITTED ANNUALLY

SELF ADMINISTRATION MEDICATION NURSING ASSESSMENT

For Students Grades K –12

NURSING ASSESSMENT: Assessment to be completed by school nurse.

1. Student is capable of identifying individual medication.	YES	NO
2. Student is able to identify specific symptoms and purpose of this prescribed medication.	YES	NO
3. Student is knowledgeable of medication dosage and method of medication administration.	YES	NO
4. Student is able to state side effect/adverse reactions to this medication.	YES	NO
5. Student is knowledgeable of how to access assistance for self emergency.	YES	NO
6. Student is capable of self-administering the prescribed medication.	YES	NO
7. Student is aware of district policy that student cannot distribute medication to another student.	YES	NO

Signature of Student:________________________________ Date:__________

Signature of School Nurse:___________________________ Date:__________

IMPORTANT NOTE: In order for a student to have access to an inhaler at all times, it is recommended that one inhaler be kept by the school nurse as a back up to the one carried by the student.

Revised 6/8/2015