Permission For Self-Carry/Self-Administration Form

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

****HEALTH CARE PROVIDER****

MEDICATION: _____Medication Allergies:_____

Dose: _____Route:_____Time:_____

Purpose of Medication_____

Through my consultation with the below named parent/guardian, as well as my own assessment of the student ("Student"), I have determined that the Student is able to identify his/her correct medication, demonstrate correct self-administration of the above listed medication ("Medication"), and has knowledge of the required dosage and timing/frequency of use of the Medication. The Student has knowledge of his/her condition and is sufficiently responsible and able to properly carry and self-administer the Medication during the school day. The Student has been instructed in the purpose, appropriate method, and frequency of use of the Medication and is capable of self-administering the Medication. A new form must be completed for all medication changes. Staff may assist student or administer medication if student is having difficulty.

Health Care Provider's Signature **Date (good for one year unless noted)**

_____

Health Care Provider's Printed Name **Phone and Fax Number**

****PARENT****

I agree to and have discussed the following with my child:

It is understood that the Medication will be self-administered solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned hereby agree(s) to release the center/school and its personnel from any and all claim(s), which they now have or may hereafter have relating to an act or omission of the Student's use of the Medication. I will be supplying the medication for my child's use and it will be kept in the original package with either a prescription label or if over-the-counter, my child's name written on it. I give permission for this information to be shared with school personnel and my health care provider may be contacted if necessary.

_____ **Date: _____ Phone: _____**

Parent/Guardian Signature

****STUDENT****

I agree to be responsible for possessing and self-administering this medication.
I agree to notify the school health office if I am having symptoms or difficulty.
I agree that the medication is only for my use, and I will use it according to the instructions.
I agree that failure to abide by the terms of this agreement and applicable policy will result in disciplinary action and/or loss of the ability to self-carry.
Middle School and High School may carry a one-day supply of over-the-counter medication without this form.
Middle School and High School may carry one day supply of prescription medication with this form.

Student Signature: _____ Date: _____

School Nurse Review: _____ Date: _____