

**REQUEST AND AUTHORIZATION
FOR STUDENT SELF-ADMINISTRATION OF MEDICATION**

Student _____ Date _____
 Grade _____ Date of Birth _____ School (circle one) High School Middle School Elementary
 Allergies _____ School Year _____

GUARDIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION OR OVER THE COUNTER MEDICATION

Medication _____ Dose _____ Route (circle) mouth eyes ear
 Time /Frequency _____ nose topical
 Continue Until _____
 Guardian Name (Print) _____
 Guardian Signature _____ Date _____

The student is capable of self administering this medication in a secure manner.
 (circle one) No Yes- supervised Yes- unsupervised

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 will store the medication in a secure location within the school building. *Inhalers and EpiPens may be kept with the student.*
4. The undersigned has reviewed the medication administration procedure with the student and believes 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 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 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.

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) _____