

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

Student _____ Date _____
Grade _____ Date of Birth _____ School _____
Allergies _____ School Year _____

PHYSICIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION

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 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.

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) _____