Student Name: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

REQUEST FOR SELF-POSSESSION/SELF-ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

Under certain conditions, as service to you and for the welfare of your child, parental requests for the self-possession and/or self-administration of necessary medication/health procedures will be honored. This request is filled out individually for each medication required to be self-carried/administered and renewed at least annually. This parental request also gives the school permission to contact the prescribing provider as necessary. **Please note**: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.

Medications MUST:

◍ Be in original pharmacy container ◍ be limited to **ONE** day supply if in the form of a pill, tablet, capsule, or caplet.

Medications MUST have a label showing the following:

◍ Student's Name ◍ Name of medication ◍ Dosage ◍ Frequency ◍ Doctor's Name ◍ Pharmacy Name ◍ Date Issued ◍ Prescription Number ◍ Expiration Date

The written statement below, signed and dated by the attending physician, supporting this signed parental request is required in order for your student to self-carry/self-administer medication.

PARENT

I am requesting permission for my child, named below, to possess and/or use the medication or perform the health procedure listed below. He/She has the maturity and ability to assume responsibility for the self-possession/self-administration of his/her medication/health procedure at school.

1. I will assume responsibility for the safe delivery of the medication and/or related equipment to and from school
2. I will immediately notify the school, in writing, if there is any change in the use of medication or health procedure and will request a new form to be filled out for the changes.
3. I release and agree to hold the Board of Education, its officials, employees, volunteers, and agents harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization

Student Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN

I recommend that _____ carry on their person and self-administer the medication listed below. This student understands when and how to use the medication and to notify an adult school staff member if medication is not effective. For inhaler medication, we recommend an extra inhaler be left in the school office.

Medication/Health Procedure: _____ Purpose/Diagnosis: _____

Dosage: _____ Time/Frequency: _____

Route of Administration: _____ Additional Directions/Precautions: _____

First Date of Administration: _____ Last Date of Administration: _____

Physician: Initial all options that apply:

____ Keep the medication and/or equipment in his/her possession for staff to administer in case of emergency

____ Keep the medication and/or equipment in his/her possession and self-administer independently

Physician Address: _____ Phone Number: _____

Physician Name (printed): _____

Physician Signature: _____ Date: _____

Imprint Physician Office Stamp Below: