JOINT SCHOOL DISTRICT NO 171

## Board Policy 3510F1: Authorization for Self-Administered Medication

Student's Name: Grade: DOB:

Parent/Guardian Name:

Telephone (Home): (Work):

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

Parent/Guardian's Signature:

Date:

**The Following Is to Be Completed by the Physician:**

I am recommending that the above named student be allowed to self-administer the following medication.

Name and Purpose of Medication:
Identification of Chronic Medical Problem:

Prescribed Dosage to be Taken:

Length of Time Medication Must be Taken:
Possible Side-Effects and/or Special Precautions to be Taken:

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**Conditions Under Which Self-Medication Will Take Place:**

☐ **Independently (Child must have had training and be proficient in self-administering medication.)**

Trainer's Name: _____ Date of Training: _____

☐ **Under the supervision of a school nurse**

**Medication should be:**

☐ Stored in the Health Office

☐ In the possession of the student

Type or Print Physician's Name: _____

Physician's Signature: _____

Date: _____