Authorization to Assist Competent Student with Self-Administration of Medications

Medication shall be administered during school hours only when required to maintain in the student's health and support the students' continued presence in school. This consent also involves Over-The-Counter (O.T.C.) medications. Parent/legal guardian shall be given the medication guidelines and sign this consent before any medication is administered to any student.

Student's Name: _____ Grade: _____

Student's School: _____ Date of Birth: _____

I request that school personnel assist the above named student to self-administer the following medication while in school and away from school for school-sponsored activities.

Physician's Name: _____ Prescription Number: _____ Pharmacy: _____

Name of Medication: _____ Dosage: _____

How medicine is to be taken (orally, topically, inhalation, injection): _____

Frequency of medication: _____ Time(s) medication is to be taken: _____

Date and time the last dose of this medication was taken: _____

Reason medication is needed at school: _____

Possible side effects, if known: _____

I understand that my son/daughter will self-administer the medication with assistance from school personnel and I declare that he/ she is competent to do so. I will assume full responsibility for any side effects and complications my child may have as a result of taking this medication.

Signature of Parent/Legal Guardian: _____

Parent's/Legal Guardian's Name: _____

Home Phone Number: _____ Work Phone Number: _____

Emergency Phone Number: _____

_____

I have received, read, and understand the medication guidelines. All questions have been answered to my satisfaction.

Signature of Parent/Legal Guardian: _____ Date: _____

SCHOOL SHALL RETAIN THIS FORM IN THE CUMULATIVE RECORD FOR THREE YEARS.