# Request for Self-Administration of Medications

Request for a student to administer his/her own medication during school hours requires complete agreement from the health care provider, school nurse, parent, and student for implementation. This form is to be on file with the school nurse.

**Student Information**

Student Full Name ____________________________________________________

Date of Birth __________ School __________________ Homeroom Teacher______________

Diagnosis _____________________________________________________________

Allergies ___________________________________ History of Anaphylaxis Yes or No _______

## Health Care Provider Statement

**To be completed by Health Care Provider**:

Name of Drug _________________________________________________________

Date to Start _____________________________Through _____________________________

Dosage and Times at school _____________________________________________________

Special Instructions for Storage and Handling _______________________________________

Possible Side Effects ___________________________________________________________

This student is ready to self-administer medication as well as is knowledgeable regarding storage and side effects. This student has demonstrated proficiency in and ability to safely administer their own medication.

Health Care Provider Signature ______________________________ Date _____________

Address __________________________________________Phone ____________________

The health care provider may be a physician, dentist, physician assistant, or a nurse practitioner/clinician.

# Student and Parent Statements

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicines will have the proper pharmacy label. If I use this medication in any manner other than prescribed, I will be subject to disciplinary actions.

Student signature ____________________________________Date _____________________

I give consent for my child to take his/her own medication during the school day. I release the school district and its employees and agents from liability for an injury arising from the student's self-administration of prescription medication while on school property or at a school related event or activity. I understand the student is responsible for carrying medication with them at all times.

Parent/Guardian Signature ____________________________ Date ______________________

School Nurse Signature ______________________________ Date ______________________

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