



Dr. Rebecca Farley
Director of Schools

Scott VanWinkle
Board Chairman

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 _____