Grades 6-12

SCHOOL HEALTH SERVICES

PRESCRIPTION MEDICATION SELF-ADMINISTRATION CONSENT FORM (PHYSICIAN'S SIGNATURE REQUIRED)

Requires renewal at the beginning of each school year

Name of Student _____ D.O.B. _____
Address _____ Telephone _____
Parent/Guardian Name _____ School _____

Diagnosis _____
Name of medication/treatment _____
Dose _____
Time(s) to be administered at school _____
Method (route) of administration _____
Medication to be administered from _____ to _____
Month/Day/Year Month/Day/Year
Precautions and reactions to observe and report _____

GRADES 6-12

_____ **I CERTIFY THAT THE ABOVE NAMED STUDENT IS CAPABLE OF SELF-ADMINISTRATION OF THE ABOVE PRESCRIBED MEDICATION.**

_____ _____ _____
Physician's Signature Telephone Date

_____ _____
PRINT Physician's Name Clinic Name

(Changes may be called to the eSchool Nurse by the prescribing provider with written confirmation following within 24 hours. Faxes are acceptable.)

I authorize my child to self-administer the above medication while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider and the school nurse to insure safe medication administration.

Parent/Guardian Signature _____ Date _____

Students are prohibited from transferring, delivering or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.