



**Permission for School Administration
of Prescription Medication**

For school use only:
 Routine PRN (As needed)
Start Date: _____

When possible, medications should be administered by a parent/guardian before or after school hours. Initial doses of a medication that a student has never taken before will not be given at school. Medication to be given at school will be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container. "Sample" medications must be provided in a container that appropriately identifies the medication and have a note signed and dated by the prescribing health provider, inclusive of student name and administration instructions.

The section below is to be completed by the prescribing health care provider:

Student's Name _____

Date of Birth _____

School _____

Grade _____

Medication: _____	Dosage: _____
Purpose of Medication ICD code: _____	Route: _____ Frequency (e.g., daily): _____
Time of Administration: _____ <i>Please note, lunchtimes may vary (10:30-1:00pm)</i>	Storage Requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (specify): _____
Number of days medication will be given at school: <input type="checkbox"/> Until end of current school year <input type="checkbox"/> _____ Weeks <input type="checkbox"/> _____ Days	Is the student allergic to any food, medications, or other items <input type="checkbox"/> No <input type="checkbox"/> Yes (List allergies): _____
Possible side effects: _____	Is this medication a controlled substance? <input type="checkbox"/> No <input type="checkbox"/> Yes
Having read the Terms of Agreement, I authorize the listed student to self-administer the above medication: <input type="checkbox"/> No <input type="checkbox"/> Yes	Having read the Terms of Agreement, I authorize the listed student to self-monitor: <input type="checkbox"/> No <input type="checkbox"/> Yes Monitoring Device: _____

Prescribing Health Care Provider's Signature _____

Practice/Office _____

Date _____

Prescribing Health Care Provider's Name _____

Office # _____

Fax # _____

The section below is to be completed by the student's parent or guardian:

I give permission for _____ to be given the above medication as prescribed. I permit the exchange of information between the school nurse or administrator, the health care provider named above, and the pharmacist who filled the prescription to discuss this medication and my student's health. I permit this form to transfer along with my student to any school within the district during the current school year. I have read and agree to the district's medication administration guidelines and will not hold the school, the district, or school personnel liable for any adverse drug reactions when the medication is administered as prescribed. I will notify the school with any medication changes.

Having read the Terms of Agreement and reviewing it in full with my student, I authorize my student to self-administer the above medication: <input type="checkbox"/> No <input type="checkbox"/> Yes	Having read the Terms of Agreement and reviewing it in full with my student, I authorize my student to self-monitor: <input type="checkbox"/> No <input type="checkbox"/> Yes
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Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name (Print): _____

Date: _____



Terms of Agreement for Self-Administration

Students will not be permitted to self-administer controlled substances and administration must adhere to all district medication guidelines. Medications will be kept by the approved student in the original labeled container, filled by the respective pharmacist. All sample medications will be kept in a container that identifies the student and the medication.

As the prescribing health care provider, my signature attests to the following:

- a) I attest that the student listed above has been instructed regarding proper use of the medication noted above (i.e., indications, actions, side effects, when to administer, when to hold administration, and when to seek assistance).
- b) I attest that the student listed has demonstrated competency for safely self-administering the medication noted above.
- c) I agree that the student listed above should be permitted to possess and self-administer the medication noted above while in the classroom, while on school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored

As the parent or guardian of the respective student, my signature attests to the following:

- a) I authorize my student to possess and self-administer the medication noted above as prescribed while in the classroom, while on school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during, before, or after-school activities on school property.
- b) I attest that my student has been instructed on the proper use of the medication noted above and has shown me that they can safely self-administer the medication.
- d) I attest that my student and I will be responsible for the proper use and safe keeping of the medication. I will not hold the school district or any of its employees or agents liable if an injury occurs related to my student self-medicating. I will be responsible for any claims costs that occur related to my student self-medicating. I understand that my student will lose the privilege to self-medicating if they endanger themselves, or another individual by misusing the medication.
- g) I understand that my student may only self-administer the medication noted above, and all other medications must be given to my child by a school nurse or designee.
- h) I understand that my student must keep their medication in the container provided by the pharmacist or the health care practitioner. The container must have my student's name, medication name and dosage, and the directions for proper use on the label.

As the medicated student, my agreement to self-administer medication attests to the following:

- a) I know when to administer the specified medication, and the signs and symptoms that mean I should not take the medication.
- b) I know how much of the specified medication I should take and how to take it in the way my health care provider has instructed. I agree to take the medication as instructed by my health care provider.
- d) I will keep the specified medication in the package provided by the pharmacy or my health care provider and will keep any needed supplies with me in a safe place.
- e) I will not allow any other students to touch or hold my medication or supplies and understand that I will no longer be able to self-administer my medication if I endanger myself or another individual by missing the medication.
- f) I understand that I can only take the medication specified in the paperwork provided by my health care professional, and all other medications must be given by the school nurse or designee.



Terms of Agreement for Self-Monitoring

Self-Monitoring is available to students who have been prescribed monitoring devices to be used during the school day related to a medical diagnosis.

As the prescribing health care provider, my signature attests to the following:

- a) The identified student has been instructed on the appropriate use of the monitoring device specified in their authorization paperwork to include indications, interpreting results, safety precautions, trouble shooting, and when to seek assistance.
- b) The identified student has demonstrated competency for safely using the monitoring device specified.
- c) I agree that the identified student should be allowed to possess and self-monitor with the device specified while in the classroom, while on school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during, before, or after-school activities on school property.

As the parent or guardian of the respective student, my signature attests to the following:

- a) I authorize my student to possess and self- monitor with the specified device while in the classroom, while on school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during, before, or after-school activities on school property.
- b) My student has been instructed on the proper use of the specified monitoring device and has shown me that they can safely use the device.
- c) My student and I will be responsible for the proper use and safe keeping of the identified monitoring device. I will not hold the school district or any of its employees or agents liable if an injury occurs related to my student self-monitoring. I will be responsible for any claims costs that occur related to my student self-monitoring. I understand that my student will lose the privilege to self-monitor if they endanger themselves or another individual by misusing the monitoring device.
- d) I understand that my student may only self-monitor with the device specified and all other devices must be used with the assistance of a school nurse or designee.

As the medicated student, my agreement to self-monitor attests to the following:

- a) I know when to use the specified monitoring device, when not to, and the signs that the monitoring device may not be working properly.
- b) I know how often to use the monitoring device and agree to use it as instructed by my health care provider.
- d) I will keep the monitoring device and any needed supplies with me in a safe place.
- e) I will not allow any other students to touch or hold my monitoring device or supplies and understand that I will no longer be able to use the device on my own if I endanger myself or another individual by misusing the device.
- f) I understand that I can only use the monitoring device specified in the paperwork provided by my health care professional, and all other devices must be used with the assistance of the school nurse or designee.