

UNIFIED SCHOOL DISTRICT 354-Claflin

PERMISSION FOR SELF MEDICATION ADMINISTRATION AT SCHOOL

Name of Student _____ Grade _____

Medication _____ Dosage _____

Date Medication Started _____ Time of day medication is to be given _____

_____ I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry the above prescribed medication and self-administer as prescribed.

Conditions under which the medication is to be given _____

Length of time medication is to be given _____

Signature of Health Care Provider

Date

My child has been instructed on self administration of the prescribed medication and is authorized to do so in school and school supervised activities.

- I certify that the child named has received at least one dose of the medication requested and has not had adverse reactions to it.
- I understand that any school employee who administers the drug to my child in accordance with written instruction from the physician or dentist shall not be liable for damages as a result of an adverse reaction to the drug.
- I understand that it is my responsibility to furnish this medication.
- I acknowledge that the school incurs no liability for any injury resulting from the self administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self administration of such medication.
- I authorize appropriate USD 354 personnel to exchange information regarding this medication request with the health care provider listed and with the dispensing pharmacy identified on the medication label.

Signature of Parent or Guardian

Date

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy or physician, stating the name of the medication, the dosage, and times to be administered.