Clinic Aide or Cluster Nurse Initial _____

Principal/Designee Initial _____

Written Authorization for Self-Administration of Medication

by Minor Children at School

**** A current prescription and physician's signature must be provided with this documentation.***

Student Name: _____

Date of Birth: _____ **Grade:** _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of (circle all that apply) asthma medication, epinephrine auto injector, seizure medication or diabetic medication by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use/ possession of his/her medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty medication and devices
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with medication
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff

I take sole responsibility for:

- the monitoring of medication, medication use, and refilling of prescriptions for medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered medication
- ensuring the student always carries his/her medication on his/her person
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication
- informing school staff in writing of any changes in the student's treatment or management
- informing the school of any exacerbations, hospital visits, and/or new or changed student medical information
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian
- coordinating distribution of the student's medical management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff)

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release the Henry County School System and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student has been instructed in the proper use/possession of my prescription medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her medication. It is my professional opinion that the student be permitted to carry and/or self-administer his/her medication. I have provided the parent/guardian with a written emergency/management plan including the name, purpose, dosage, and administration directions of the medication.

_____ _____

Physician's Signature Date