Medication Expiration Date: ____________

SELF MEDICATING STUDENT AGREEMENT
REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS
(INHALERS/EPI-PENS)

Student's Name: _________________________ Grade: ____ DOB: ________ School: ______________

Medication: ___________________________________ Dosage: __________ Route: (circle) Inhale / Injection

Time medication to be given: AM ___________ PM ____________

Please circle: Before After With Meals 15 minutes before exercise According to EmergencyActionPlan

Reason medication is prescribed: ____

Start Date: ________________________ Stop Date: ________________________(1 year)

Significant information (include side effects, toxic reactions, and omission reactions: ______________

____

Contraindications: ____

I agree that this student is authorized to medicate himself/herself, has been instructed and has demonstrated the skill level necessary to use the prescribed medication/device. In order to keep this child in optimum health and to aid school performance it is necessary that this medication be self-administered during school hours. The student's parent/guardian has been informed and is in full agreement.

____ Date____________________

Licensed Health Care Provider Signature

Parent/Guardian Permission

I, _________________________ agree that my child _________________________is knowledgeable of his/her treatment and is capable of self-administering the medication. I hereby give my permission for my child to receive medication during school hours. As the parent/guardian of this child, I assume the responsibility of any adverse reactions this medicine may cause for my child. I agree to send the medication in its original container. I understand that the school and its employees are not liable for an injury arising from a student's possession and self-administration of this self-administered medication. I understand that I should provide the school with backup asthma medication that shall be kept at school in a location to which the student has immediate access in the event of an emergency. I give permission for the school to fax this medication form to my child's health care provider (if needed) for their signature. I give permission for my child's health care provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

Signature of Parent/Guardian____

Telephone number______________________________ Date_______________________

Self-Medicating Student Agreement

I agree and understand how to take my medicine as prescribed by my doctor. I will not share my medicine with anyone. I will keep my medicine in a safe and secure place away from other students. I understand that if I do not follow the above rules, I may lose my privilege to give myself my own medicine.

____ _________________________

Signature of Student Date

(Please complete and return form to the school office)