

**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: _____

Time medication to be given: AM _____ PM _____

Please circle: Before After With Meals As Needed

Reason medication is prescribed: _____

Start Date: _____ Stop Date: _____

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)