

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL
(Only for auto-injectable epinephrine or inhaled asthma medication)

Student: _____ Birth Date: _____

School: _____ Teacher: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

<u>Medication 1</u>	<u>Medication 2</u>
Medication name: _____	Medication name: _____
Reason for Medication: _____	Reason for Medication: _____
Dose: _____	Dose: _____
Method of Administration: _____	Method of Administration: _____
Time of Administration: _____	Time of Administration: _____
Start: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____	Start: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____
Stop: <input type="checkbox"/> End of <input type="checkbox"/> Other Date/Duration: _____	Stop: <input type="checkbox"/> End of <input type="checkbox"/> Other Date/Duration: _____
Year _____	Year _____
<input type="checkbox"/> For episodic/emergency events only	<input type="checkbox"/> For episodic/emergency events only
Restrictions and/or important side effects	Restrictions and/or important side effects
<input type="checkbox"/> None anticipated	<input type="checkbox"/> None anticipated
<input type="checkbox"/> Yes, please describe: _____	<input type="checkbox"/> Yes, please describe: _____
_____	_____
Special Storage Requirements:	Special Storage Requirements:
<input type="checkbox"/> Refrigerate <input type="checkbox"/> None	<input type="checkbox"/> Refrigerate <input type="checkbox"/> None

<p><u>This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication</u></p> <p><input type="checkbox"/> Yes - Supervised <input type="checkbox"/> Yes - Unsupervised <input type="checkbox"/> No</p> <p>This student may carry medication:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please indicate any additional information</p>	<p><u>This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication</u></p> <p><input type="checkbox"/> Yes- Supervised <input type="checkbox"/> Yes - Unsupervised <input type="checkbox"/> No</p> <p>This student may carry medication:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please indicate any additional information</p>
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Health Care
Provider's Signature: _____ Date: _____

Phone # _____ Address: _____

The school nurse or other authorized school personnel will administer the medication at school, unless otherwise indicated by the health care provider

**CONSENT
FOR SELF-ADMINISTRATION OF MEDICATION
RELEASE OF MEDICAL INFORMATION
AND RELEASE OF LIABILITY**

I hereby consent for my child, _____ to self-administer the following medication during the regular school day or when attending school related activities:

Auto-injectable epinephrine

Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by: _____

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency, of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, exectuors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, its officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

Date

Signature of Parent/Guardian

Date _____ Reviewed by School Nurse

Printed Name of Parent/Guardian

(Signature) _____

Asthma Contract Attached

Date _____ Reviewed by Principal

(Signature) _____

This request **MUST** be updated annually and medication claimed within one week beyond the end of the school year.