WARREN CONSOLIDATED SCHOOLS

Student: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

REQUEST FOR SELF-POSSESSION/SELF-ADMINISTRATION OF MEDICATION

Dear Parent/Guardian,

Under certain conditions, as a service to you and for the welfare of your child, parental requests for the self-possession and/or the self-administration of necessary prescribed and/or over-the-counter medications/health procedures for students will be honored.

Prescription Medication: ● Must be in Original Pharmacy Container ● Provide Student's Name ● Name of Drug ● Dosage ● Frequency ● Doctor's Name ● Pharmacy Name ● Date Issued ● Prescription Number ● Expiration Date

If medication is in pill, tablet, caplet, or capsule form, container should be limited to **ONE** day supply.

The written statement below, signed and dated by the attending physician, supporting the signed parental request is required in order for your student to self-carry/self-administer medication.

PARENT

I am requesting permission for my child named below to possess and/or use the medication(s) or perform the health procedure listed below. He/she has the maturity and ability to assume responsibility for the self-possession/self-administration of his/her medication/health procedure at school.

1. I will assume responsibility for the safe delivery of the medication and/or related equipment to and from school.
2. I will immediately notify the school in writing if there is any change in the use of the medication or health procedure.
3. I release and agree to hold the Board of Education, its officials, employees, volunteers and agents harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

Student Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN

I recommend that _____ carry on their person and self-administer the medication listed below. This student understands when and how to use the medication and to notify an adult school staff member if medication is not effective. For inhaler medication, we recommend an extra inhaler be left in the school office.

Medication/Health Procedure: _____ Purpose/Diagnosis: _____

Dosage: _____ Times/Frequency: _____

Route of Administration: _____ Additional Directions/Precautions: _____

First Date of Administration: _____ Last Date of Administration: _____

Physician: initial all options that apply

_____ Keep the medication(s) and/or equipment in his/her possession for staff to administer in case of emergency.

_____ Keep the medication(s) and/or equipment in his/her possession and self-administer independently.

Address: _____ Phone Number: _____

Physician Name (printed): _____

Physician Signature: _____ Date: _____

Imprint Physician Office Stamp Below:

Updated: 5/18/20