

**St. Mary's Grade School**  
**STUDENT SELF-ADMINISTRATION OF MEDICATION**

**Directions for Parent:** Please complete this form if you want your child to self-administer prescription medications. Self-administration of medication will only be allowed in limited cases when your child's health care provider determines he/she must have immediate access to, and be capable of, storing the medication. **(IMPORTANT: If you want your child to self-administer an inhaler for asthma or Epi-pen for severe allergic reactions, state law requires you to use different forms. Those forms are available from your health care provider or from our school office.** Thank-you for your cooperation!

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**A. INFORMATION ABOUT MEDICATION** (Please print):

Name of Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Route (Circle One: Injection Inhaled/Nasal By Mouth Other/Please Specify: \_\_\_\_\_  
Reason for Medication: \_\_\_\_\_ Continue Until: \_\_\_\_\_  
Major Side Effects: \_\_\_\_\_  
Related Medical Supplies this Student Must Store in School: \_\_\_\_\_

Expiration of Authorization: This authorization shall remain in effect for one school year (including summer school programs after this school year) unless an earlier expiration date is provided here: \_\_\_\_\_  
(Please note that new "Authorization" forms must be completed prior to the start of each new school year).

**B. AUTHORIZATION OF HEALTH CARE PROVIDER** (Required)

I authorize this individual to self-administer the medication listed above. I verify that this individual may need to self-administer this medication immediately as indicated in the "Reason for Medication" listed above, and recommend that he/she be allowed to carry such medication on his/her body, or store in a secure area of the school that allows his/her immediate access.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**C. AUTHORIZATION OF PARENT** (Required)

I request permission for, and authorize my child to self-administer the above-named medication during school hours and school-sponsored activities. I also acknowledge and understand the following:

- I have provided or arranged for the provision of information/training about the above-named medication to my child, and believe he/she understands and is capable of self-administration of this medication.
- I will notify the school immediately if my child's health changes, or there is a cancellation of this medication.
- School personnel and/or medical personnel working on behalf of the school will not be responsible for the administration of this medication, and will not monitor the child's failure to self-administer it. My child and I shall be solely responsible to ensure the medication is taken as prescribed.

In exchange for granting my request to permit my child to self-administer the above-named medication, I agree as follows:

- (1) To indemnify, defend and hold harmless St. Mary's Grade School, its officers, employees and all other individuals working in their official capacities on behalf of St. Mary's Grade School from any claim or liability for injuries or damages resulting from the self-administration of the above-named medication; and (2) To acknowledge that I will not seek any recovery from the District for any claim or liability for injury or damages, including without limitation reasonable attorneys fees and costs, caused or claimed to be caused by the self-administration of the above-described medication.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_