

HEALTH SERVICES

Medication Self-Administration Consent Form

Student Name _____ DOB _____ Grade _____

Students with a chronic disease or medical condition are permitted to carry and self-administer prescription labeled emergency medication at school and at after school activities for immediate use in a life-threatening situation upon written order of health care provider with prescriptive authority, parent/legal guardian request, and school nurse (RN) approval.

IC 20-33-8-13 Possession and self-administration of medication permitted As added by P.L.1-2005, SEC.17.

PARENT/GUARDIAN STATEMENT

As parent/guardian of _____, I permit him/her to carry and self-administer the below ordered emergency medication. I take responsibility for this permission and verify that my child has been trained in the proper administration of this medication including when to take it, the appropriate dosage, and how to manage the side effects. My child understands that should he/she self-administer the below ordered emergency medication, the school nurse (RN) or coach is to be informed immediately. My child understands not to share this medication with anyone else. I understand that the medication must be in the original pharmacy labeled container, with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and direction for use. ***I will notify the school immediately if the medication is changed or discontinued and understand that the school nurse (RN) may contact the physician or pharmacist regarding this medication.*** I agree to defend and hold the school district employees harmless from liability for the results of the medication or the manner, in which it is administered, and to defend and indemnify the school district and its employees and coaches for any liability arising out of these arrangements.

Parent/Guardian Signature _____ Date: _____

Student acknowledges the requirements with signature _____

TO BE COMPLETED BY PRESCRIBING PHYSICIAN:

This medication is required during school and after school hours to improve or maintain the health of this student. The school nurse (RN) may contact me regarding this medication.

_____ has been diagnosed with _____

and must carry and self-administer (Name of Medication) _____
(PLEASE PRINT)

(Dosage) _____ (Side effects to be noted/reported) _____

Other recommendations _____

- I have instructed this patient (with return demonstration) in the proper way to administer his/her medication. It is my professional opinion that he/she should be allowed to carry and self-administer this medication.
- The parent/legal guardian will supply additional emergency medication, indicated above, to be kept in the school clinic in case the student fails to have the self-carry medication.
- It is my professional opinion that this patient should NOT carry and self-administer this medication.

(Physician's signature) (Physician's name-PRINTED) (Date)

(Office phone number)

School Nurse (RN) Signature _____ Date _____ **APPROVED DENIED

***The school nurse (RN) will permit and assist the student to be responsible, but reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk.*