MEDICATION AUTHORIZATION FOR SELF-ADMINISTRATION

Caswell County Schools

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name: _____ Date of Birth: ___/___/___

School: _____ Telephone: _____ Fax: _____

The above named student has a medical condition that requires self-medication at school. I have received the Caswell County Schools Self-Administration Policy and agree that this student has the knowledge and maturity to self-manage his/her medication safely and correctly.

Medication: _____ Dosage: _____ Route: _____ Frequency: _____

Time(s) medication is to be given: _____ Dates to be given from: ___/___/___ to ___/___/___
(Medication request will be in effect until the beginning of the next school year unless otherwise specified.)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effects, adverse & omission reactions): _____

This medication will be furnished by parent or guardian in a pharmacy labeled container with identifying information (i.e. name of child, medication dispensed, dosage prescribed and time to be given).

Physician Signature: _____ Physician Name (print): _____

Telephone: _____ Date: ____/____/____

I have read the Caswell County Schools Self-Administration Policy and I agree that my son/daughter named above has sufficient maturity and knowledge to use the above prescribed medication safely and correctly. I understand that:

- The only liability which the school can assume is to comply with the terms of this policy.
- The school can assume no liability for monitoring the self-administration, including the frequency and dose or the failure to self-medicate when necessary.
- My son/daughter must comply with the procedures outlined on this form.

Parent Signature: _____ Telephone: _____ Date: ___/___/___

I have read the Caswell County Schools Student Self-Administration Policy and I agree that I have sufficient maturity and knowledge to use the medication named above safely and correctly. I agree to:

- Keep medication I my possession at all times and not leave it in a place accessible to other students.
- Not allow or offer any use to other students
- Use medication in a responsible manner, in accordance with my physician's orders.
- Notify the school office or school nurse if I am having more difficulty than usual with my health condition.

Student Signature: _____ Date: ___/___/___

Review with Student:
_____ Demonstrates correct use/administration of medication
_____ Recognizes need and proper timing for medication as prescribed by physician
_____ Identifies a proper location and method to carry medication
_____ Knows health condition well
_____ Keeps a second labeled container in nurse's office or main office (as indicated)
_____ Review Emergency Action Plan
Nurse: _____ Date: ___/___/___ Principal: _____