NICE COMMUNITY SCHOOLS
MEDICATION SELF-ADMINISTRATION PLAN AND AUTHORIZATION (Y5-12)

Student's Name_____ _____ DOB_____ Grade___ Teacher/Classroom_____
Date Form Received by School _____

SELF-ADMINISTRATION OF PRESCRIBED INHALERS FOR RESPIRATORY PROBLEMS, MEDICATION FOR ALLERGIC REACTIONS AND INSULIN FOR DIABETICS will be allowed. ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER, clearly labeled, indicating the following information: student's name; name and dosage of medication; method of administration; date issued; and doctor's name.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child) _____ be allowed to self-administer the medication listed below at school according to school policy.

I understand that:

(a) my child is responsible for administering his/her medication.
(b) it is my responsibility to notify the school of change or discontinuation of the medication(s).
(c) the school is not responsible for determining the number of times the medication is to be used by a student.
(d) if there is a misuse of the medication, it will be taken away from the student.
(e) I have the option of requesting school employees to administer the medication listed below in the presence of another adult.

By authorizing self-administration of medication for my child, I waive the option of school employee administration and understand that the building administrator, teacher, or other school employees are not liable for my acts, or the acts of the child in self-administration of this medication.

Signature _____ Relationship_____ Date_____ Phone_____

TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER

Name of medication _____

Reason for medication (OPTIONAL)_____

Form of medication/treatment: ____Tablet/capsule ____Liquid ____Inhaler ____Injection ____Other
Instructions (schedule and dose to be given at school) _____
Start Date form received _____ Other dates _____
Stop End of school year _____ Other date/duration _____

Restrictions/important side effects ____ None anticipated ____Yes, please describe_____

This student is both capable and responsible for self-administering this medication
____No ____Yes, Supervised ____Yes, Unsupervised
This student may carry this medication ____No ____Yes

Health Care Provider's Name _____

Address _____ Phone _____

Date _____ Signature _____

Building Administrator'sSignature_____Date_____

Nurse's Signature_____Date_____