Medication Administration Authorization for
Student Self-Management and Self Carry

Student Name _____ Grade _____ School _____

This agreement is only valid through the current 20____ school year,

Any student who wishes to carry and take their own medication, including field trips, sport, and/or activity trips, must have this authorization signed by all parties listed below as well as their Action Plan (if necessary) attached to the document (i.e. if diabetic, asthmatic, epileptic etc. and carry own medications).

Student Agreement

I will use the prescription medication only as permitted by the attached Action Plan (if necessary) or the Authorized Medication form attached (if necessary). I will NOT share it with others. I have been instructed by a physician how to self-administer this medication and understand the side effects of improper use and will promptly report self-administration errors and follow the guidelines with the school policy. I understand that I may request assistance from qualified school health personnel at any time during the school day. I understand that if I do not abide by these terms, I may be disciplined and that this Action Plan (if necessary and attached) will be re-evaluated.

Student Signature _____ Date _____

Parent/Guardian Authorization and Approval for Self-Management

As the parent/guardian for the student, I hereby accept and agree to the attached Action Plan (if necessary) or the Authorized Medication Form (if attached). I agree that if the student injures school personnel or another student as result of the misuse of necessary medical medication, supplies, or equipment, that I am responsible for any and all costs associated with such injury. I acknowledge that (A) the school and its employees and agents are NOT liable for any injury or death arising for the student's self-management of the health condition and I will release the school from any such claims as well, and (B) I shall and do hereby agree to indemnify and hold harmless the school and its employees and agents against any claim arising from the student's self management of said health condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for this school calendar year listed above.

Parent/Guardian Signature _____ Date _____

Physician Authorization and Approval

I have reviewed and approve the attached Action Plan (if necessary and attached). The student has the ability to safely and responsibly self-manage his/her condition in accordance with this plan or their health plan.

Physician Name (Printed) _____ Phone # _____

Physician Signature _____ Date _____

School Nurse (RN) Approval

I have reviewed and approve the attached Action Plan (if necessary and attached). The student has the ability to safely and responsibly self-manage his/her condition in accordance with this plan or their health plan.

RN _____ Date _____

*To be used for self-carry of inhalers or self-management of Asthma, Diabetes, Epilepsy, etc.