

WARREN CONSOLIDATED SCHOOLS

Student Name

REQUEST FOR SELF ADMINISTRATION/SELF POSSESSION

OF

PRESCRIBED AND NON-PRESCRIBED MEDICATIONS AND MEDICAL PROCEDURES BY STUDENTS

Secondary students only. Elementary students only in rare, life-threatening circumstances.

Dear Parent,

Under certain conditions, school personnel may consent to parental requests for self administration/ self possession of medication or medical procedures. Medication must be brought to the school in a properly labeled container indicating the following information: student name, name of drug, dosage, frequency and physician's name.

Student and Parent Information

Name _____ School _____ Date _____ Grade _____

Address _____ City _____ Zip _____ Date of Birth _____

Medication or Procedure #1 _____ Purpose/ Diagnosis _____

Dosage _____ Time _____ Frequency _____ Route: by Mouth (circle) Inhaled Applied to skin Other: _____

Starting Date _____ Ending Date _____

Medication or Procedure #2 _____ Purpose/ Diagnosis _____

Dosage _____ Time _____ Frequency _____ Route: by Mouth (circle) Inhaled Applied to skin Other: _____

Starting Date _____ Ending Date _____

Initial all Options that apply :

- Self administer in the presence of an authorized staff member.
- Self administer medication or procedure independently
- Keep the medication(s) or equipment in his/her possession for staff to administer in case of emergency.

I am requesting permission for my child named above to use the medication or perform the medical procedure listed above. He/she has the maturity and ability to assume responsibility for self administration/ self possession of his/her medication at school.

- A. I will assume responsibility for safe delivery of the medication and/or related equipment to and from school.
- B. I will immediately notify the school if there is any change in the use of the medication or the procedure.
- C. I release and agree to hold the Board of Education, its officials, and it s employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent Printed Name _____ Parent Signature _____ Date _____

Parent name, signature and phone numbers are required for all medications and medical procedures

Parent Name(s) _____ Parent Signature _____ Address/zip _____

Home Phone _____ Work Phone _____ Mobile or Emergency # _____

Physician name, signature and phone number are required for all medications and medical procedures

Physician Printed Name _____ Physician Signature _____

Address/zip _____ Phone Number _____

Report the following adverse reactions to my office immediately: