PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name: _____ **DOB:** _____

Allergies: _____

Medication: _____ **Dosage:** _____

Reason for medication or diagnosis: _____

School: _____ **School Year:** _____

In order for students to self-administer medication at school, the Parent/Guardian shall provide this signed authorization form. Also, a Physician's Order (see box below) is required for students to self-administer medication. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

* It is recommended that only middle and high school students are allowed to carry and self-administer their own medication. For elementary age children, arrangements can be made to keep inhalers or emergency medications in the classroom. The student's teacher will provide monitoring for the child's safety.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis): _____ and have determined that he/she requires medication during school hours.
2. Name of Medication _____ 3. Dosage & Route: _____
4. I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. **Please check: ____YES _____ NO**

Physician's Signature: _____ **Date:** _____ **/** _____ **/** _____

Printed Name: _____ **Phone:** _____

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent(s)Guardian(s) of* _____ *give consent for* *****my student to self-administer*** *the above medication(s). I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.*

The School Nurse reserves the right to monitor student periodically during the school year.

* ***Parent / Student are responsible to have the medication available at school.***

X _____ ____ **/** ____ **/** ____

(Parent/Guardian Signature) Date

Home Phone: _____Work**:** _____Cell: _____

Reviewed by: _____ RN Date: _____