Student Services

Administering Medicines to Students

ACKNOWLEDGEMENT OF STUDENT SELF ADMINISTRATION OF MEDICATION

As parents/guardians of (Students Name) ____ we authorize our son/daughter to possess and to self-administer medication to treat his/her chronic health condition.

We warrant that:

1. A licensed physician prescribed or ordered such medications for use by our son/daughter.

2. A licensed physician has instructed our son/daughter in the correct and responsible use of such medications.

3. Our son/daughter has demonstrated to our son/daughter's licensed physician or licensed designee the skill necessary to use the medication and any device necessary to administer such medications.

4. Our son/daughter's physician has approved and signed a written treatment plan for managing our son/daughter's chronic health condition that describes the specific medications to be self-administered and the medication's appropriate use by our son/daughter. The treatment plan includes a physician's statement that our son/daughter is capable of self-administering the medication under the treatment plan. A copy of this treatment plan is attached to this acknowledgement.

5. We agree to complete and submit to the school any written documentation required by the school.

______________________________ ______________________

Parent/Guardian Signature Date

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WE ACKNOWLEDGE THAT THE SCHOOL DISTRICT AND ITS EMPLOYEES SHALL INCURE NO LIABILITY AS RESULT OF ANY INJURY ARRISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY OUR SON/DAUGHTER OR ANY ADVERSE EFFECTS OR INJURY CAUSED BY THE MEDICATION AS ADMINISTERED BY SCHOOL STAFF. HOWEVER, WE ALSO ACKNOWLEDGE THAT THE ABOVE STATEMENT SHALL NOT BE CONSTRUED AS A RELEASE FROM LIABILITY FOR NEGLIGENCE.

__________________________________ ____________________
Parent/Guardian Signature Date

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