Unified School District 233

AUTHORIZATION FOR SELF MEDICATION

Emergency Asthma/Allergy Medications

AUTHORIZATION FOR SELF MEDICATION

PART A: ***Parent to Complete*** **– for students K-12**

Name of Student: ______________________Date of Birth: ________School: _______ Grade: _______

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

___________________________	___________________________	_______________
Parent Signature	Parent (Printed Name)	Today's Date

Part B: *Physician to Complete*

Medication	**Purpose**	**Dosage**	**Time / Frequency**
__________________	_________________________	_____________	____________________
__________________	_________________________	_____________	____________________
__________________	_________________________	_____________	____________________

Conditions & Special Circumstances for use: ____

Length of time medication is to be administered: ____

___________________________	___________________________	_______________
Physician Signature	Physician (Printed Name)	Today's Date

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Physician Phone Number

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Part C: *School Nurse to Complete*

School Nurse Review of order and procedure with the student. Completed ________________________
Date of Review

RETURN TO SCHOOL NURSE

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