SELF-MEDICATION FORM FOR STUDENTS WITH ASTHMA OR OTHER LIFE THREATENING ILLNESSES

Student's Name_____ Age_____ Grade_____
School _____
Name of Medication_____
Dosage_____ Frequency_____Route of Administration _____
Possible Side Effects_____
Specific Nature of Student's Illness/Condition_____
Effective Dates of Medication: From_____To _____

It is my understanding that the school nurse in _____School charged with the administration of medication may rely upon my directions as contained in this document. Students with asthma or other potentially life-threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and/or prevention of life-threatening illnesses or conditions during school hours, athletic events and practices, and field trips.

I hereby deem the above-named student to be sufficiently capable, having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his/her prescribed medication on his/her person and give authorization for self-medication of the medication listed above. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from attending physician.

Physician's Name (print)_____
Physician's Signature_____ Date _____
Physician's Address_____ Telephone_____

****

As parent/guardian of the above-named child, I hereby request permission for my child to self-administer and have possession of his/her medication as described above and release_____School and its employees and its agents from liability for damages my child may suffer as a result of this request.

I realize self-management privileges are lost if he/she does not use medication properly. Students deemed responsible may carry their prescribed medication on their person, but must report to the school nurse with the above-mentioned medication before this policy can be instituted.

I also realize permission is effective for this school year and must be renewed yearly.

I agree that I shall indemnify and hold harmless_____School and its employees or agents against any claims arising out of the self –administration of medication by the pupil.

Parent Signature_____ Date _____

Home Telephone_____Work Telephone_____

NOTE: 1. A separate dose of medication must be kept in the nurse's office.
2. Medication brought to school must be prescription labeled.