



MEDICATION SELF-ADMINISTRATION

DURING SCHOOL DAY

POLICY JGCD-E (1)

When possible, medications should be given to students before or after school hours by the parent or guardian. Medications must be in the originally labeled container.

Please, complete a separate form for each medication to be self-administered.

Student Name:		Date of Birth:
School:	Grade:	Teacher:

Is your student allergic to any food, medicine, or other items? No Yes (if yes, list allergies)

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication to be taken: If possible, specify preferred time. <input type="checkbox"/> To be taken only as needed per container/package directions	Period of time medication to be given: <input type="checkbox"/> Until the end of school year <input type="checkbox"/> ____ school days <input type="checkbox"/> ____ weeks
Possible side effects:	

Health Care Provider's Signature Required For All Self-Administration Medications	
Prescribing Health Care Provider's Signature:	Date:
Stamp, Print, or Type Health Care Provider's Name & Address	Office Phone Number
	Office Fax Number

I give permission for the above student to keep the above medication with him/her during the school day. My student understands the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. My student also understands that this medication is not to be distributed to any other student or district employee. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about self-administration of medications before self-administration of this medication will allowed at school. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent/Guardian	Print or Type Name of Parent/Guardian	Date
Signature of Student	Print or Type Name of Student	Date

FOR SCHOOL USE ONLY	Approved: _____ Principal or School Designee	Date: _____
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