Self-Administration Authorization of Over-the-Counter Medications or Homeopathic Remedies

To Be Completed By Parent/Guardian

I request and authorize my child _____ to carry and/or self-administer their OTC medication or homeopathic remedies_____

_____.

This authorization is given and based on the following:

I understand that my child shall be permitted to self-administer the OTC/homeopathic remedies as long as they do not endanger him/herself or other persons, and will not misuse the OTC/homeopathic remedies. I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-administer OTC/homeopathic remedies at school as instructed and I authorize reciprocal release of information related to my child's health/medications between the school nurse and the healthcare professional/clinic.

_____ _____

Signature of parent/guardian Date

School Year: _____

Student Agreement

Medication is permitted in accordance with district policy and procedures. The student name must appear on the medication container, inhaler, injector, etc.

I, _____ agree to the responsibilities of carrying medication.

_____ The student can demonstrate correct use/administration.

_____ The student can recognize the correct dosage.

_____ The student recognizes proper and prescribed timing for medication.

_____ The student agrees to not share the medication with others.

_____ The student will keep the medication in an agreed upon location.

(please indicate location)_____

_____ The student will notify the Health Services Office under the following circumstances:

- Symptoms continue or get worse after taking the medication.
- Suspect that I am experiencing side effects from the medication.
- Other_____

_____ _____

Signature of Student Date