

Student Self-Administration Medication Permission Form

Student Information:

Student's Name _____ Age _____ Weight _____

Teacher's Name _____ Grade _____

Parent/Guardian's Name _____

Parent/Guardian's Address _____ City _____ State _____

Phone # (Home) _____ (Work) _____ (Mobile) _____

Doctor's Name _____ Doctor's Phone # _____

Emergency Contact _____ Phone # _____

Medical Information:

Name of Medication _____ Route (by mouth, etc.) _____

Purpose of Medication _____

Time to be Administered _____ Dosage _____

Possible or Common Side Effects _____

Termination Date for Administering Medication _____

Administration Procedures:

1. All medication sent to school must be in its original, pharmacy labeled container. The empty container or any unused medication will be returned to the parents at the end of the administration period.
2. Prescription and over-the-counter medication is given only according to the labeled instruction on the container.
3. Over-the-counter medication must have the student's name affixed to the container.
4. The signed instruction form is kept on file in the school office.
5. No medication is kept by the child or classroom teacher except for inhalers in compliance with the CDS Asthma/Respiratory Condition Protocol and medications required by a student's IHP/Action Plan.
6. Children go to the office for medication except for inhalers in compliance with the CDS Asthma/Respiratory Condition Protocol and medications required by a student's IHP/Action Plan.
7. All medication must be self-administered by the student with the assistance of a CDS staff member and taken in the presence of a CDS staff member.
8. A record of the administration of medication is kept on file in the school office.
9. Medication is kept in a locked area of the school office.

The parents of the child must inform the school administration or teacher of any changes in the child's health or change in medication.

Parent: Please Read, Sign, and Date:

My child has permission to self-administer the medication as described above with assistance from a Central Day School staff member and/or administration. My child is competent to self-administer this medication. My child's condition for which the medication is authorized is stable.

Parent's Signature

Date