New Hope-Solebury School District
School Health Services
Authorization to Self-Administer Medication

Signatures are required if medication will be carried by the student and self-administered, if needed. Authorizations must be updated every school year.

Note: Self-administration of medication must be done under the observation of a staff member. It is advised that younger students, or newly diagnosed students NOT carry their medication with them unless absolutely necessary, and that all medications should be kept in the health offices where student can be assessed and use of medication can be monitored by the school nurse.

I hereby grant permission that _____ be permitted to carry and administer, if needed, his/her emergency asthma inhaler or epinephrine injection during the school day, or during field trips.
(Please complete the medication permission/treatment form on reverse side)

_____ _____/____/____ _____
Signature of Licensed Prescriber **date signed** **Phone number**

_____ _____/____/____ _____
Signature of Parent/guardian **date signed** **Phone number**

As a parent signing, **I also grant permission that my child's condition be shared with my child's teachers and staff over-seeing his/her care.**

Guidelines for Student Self-Administration:

1. A student is permitted to use his or her <u>own</u> medication only, no sharing!
2. Self-administering of medication <u>must</u> be done under the observation of a school staff member.
3. Medication is to be labeled clearly with the students name, date dispensed, Dr.'s name, and directions for taking.
4. Medications are to be used by the student <u>only</u> as directed.
5. A permission form (with physician, parent, & student signature) will be on file in the health office and renewed annually.

I accept responsibility for having in my possession and self-administering the medication, indicated for school use, and agree to adhere to the student guidelines listed above.

Student's Signature_____Date_____

Please notify the school nurse in writing if there is a change in the student's condition, medication or treatment

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MEDICATION/TREATMENT DISPENSING FORM

The following to be completed by the licensed prescriber

Patient's name _____ Date _____

Name of medication _____

Dosage _____ Time to be given _____ Route _____

Reason for Medication/Treatment_____

Directions _____

Effective dates _____to_____

Allergies _____

It is my understanding that the employees of the New Hope-Solebury School District charged with the administration of this treatment/procedure during school hours may rely on directions contained in this document. I further certify that I am the physician/dentist who prescribed the treatment/procedure and that the student named above is under my supervision as a patient.

Licensed Prescriber signature _____

Licensed Prescriber name printed _____ Phone: _____

Parent/Guardian Consent

I give my permission for my child,

_____, to receive the following medication ordered by a licensed prescriber during the school day and release the New Hope-Solebury School District and its employees from liability for any damages my child may suffer as a result of this request. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature _____ Date _____

Parent/Guardian name printed _____ Phone: _____