**JLCD-E**

# AUTHORIZATION TO SELF-ADMINISTER MEDICATION

**Notice: Pursuant to Kansas statute, neither the Shawnee Mission School District, nor its employees, nor its agents shall be liable for any injury resulting from self-administration of medication.**

1. Statement of medical provider:

I, _____ state that _____
Name of medical provider Name of student
has been instructed on the self-administration of the medication listed below and is authorized to do so in school:

Name and purpose of the medication:_____

Prescribed dosage:_____

Time of regular administration of the medication (if any):_____

Other special circumstances for administration of the medication (if any):_____

_____

Duration of prescription:_____

_____
Signature of medical provider

2. Statement of parent or guardian:

I, _____, state that I am the ___ parent ___ guardian of
Name of parent or guardian
_____. I hereby authorize self-medication by above-named student,
Name of student
in school, and I acknowledge that the student has been instructed on the self-administration of the medication identified in the statement of the medical provider. I acknowledge that neither the Shawnee Mission School District, nor its employees, nor its agents shall be liable for any injury resulting from self-administration of medication. Furthermore, I agree to indemnify the Shawnee Mission School District, its employees, and its agents for any claims relating to the self-administration of such medication and to hold each harmless from any such claims.

_____ _____
Signature of parent or guardian Date

Exhibit #1
Adopted: 7-11-05