AUTHORIZATION TO ASSIST COMPETENT STUDENT WITH SELF-ADMINISTRATION OF MEDICATION

Medication shall be administered only when the student' health requires that it be given during school hours. It is the parent/guardian's responsibility to bring this medication to school and remove any unused medication when treatment is completed.

All prescription medication must be brought in the original container. The pharmacy label must include the following information:

Name of Student
Prescription Number
Name of Medication and Dosage
Administration Route or Other Directions
Date
Licensed Prescriber's Name
Pharmacy Name, Address and Phone Number

Comments: ____

All non-prescription medication must be brought to school in the original manufacturer's labeled container with the ingredients listed and the child's name affixed to the container.

PARENT/GUARDIAN AUTHORIZATION

No more than one month's supply of any medication should be brought to school.

Grade/Homeroom Student's Name Date I request that school personnel assist the above named student to self-administer the following medication while in school and away from school for school activities. Name of Medication: _____ Amount to be taken:_____ How medication is to be taken (orally, topically, inhalation, injection) ______ Time(s) medication is to be taken: ______ Date the last dose is to be taken: _____ Reason medication is needed at school: Date: / / Signature of Physician (if requested by the principal) It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or quardian. In consideration of the acceptance of the request to perform this service by any person employed by Rogersville City School, the undersigned parent/guardian hereby agrees to release the Rogersville City School and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication. Parent/Guardian Signature: ______ Date: _____ Parent/Guardian Printed Name: ______ Work Phone:_____ Home Phone: _____