MONONA GROVE SCHOOL DISTRICT

Carry & Self Administer Prescription & Non-Prescription Medication (Except controlled substances & *Inhalers)

(For Students in 6th grade or higher ONLY)

Date: _____ This form is **valid only one year!**

Student's Name: _____ **Grade:** _____

Name of Medication(s): _____

Dosage: _____ **Time(s) to Administer:** _____

(For Prescription Medication Only, Fill Out Physician's Name & Phone Below)

Name of Prescribing Physician: _____ Phone # _____

Parent/Student Responsibilities - I the parent/guardian of the above named student give my permission for him/her to carry or keep in his/her locker and self-administer the above named medication(s) as I and/or our physician have instructed him/her. He/She understands the purpose, appropriate method and frequency in which to take this medication. I consider him/her to be a responsible person in self-administering this medication and **I have made him/her aware that this medication is not to be shared with his/her peers.**

If it is determined at a later date that this student is abusing this privilege, other arrangements shall be made.

Legal Information - I further agree to hold Monona Grove School District and their personnel harmless and I will accept all responsibility in any or all claims arising from the carrying or keeping and self-administration of this medication by the above named student.

I understand that all **prescription medication** must be kept in a **valid (not expired**) pharmacy container that contains a label with the following information:

1. The Student's full name.
2. Name of drug & dosage.
3. Frequency of administration.
4. Name of physician.
5. Name & number of pharmacy.

Parent/Guardian signature_____

Date_____ **Phone (Home)** _____**(Work)** _____

***Inhalers** now require **Parent/Guardian and Physician signatures** for self-administration. Please request inhaler form in the main office or see website – www.mononagrove.org.

Revised 04/07 lkn