Laurel Public Schools
Parent Consent for Student Self-Administration of Medication

Name of Child: _____DOB: _____School: _____

Grade: _____ School Year: _____

* The initial dose must be given at home.
* Medication must be furnished in a current original pharmacy container with student's name, name of medication, strength, and dosage to be given. Non-prescription medication must be furnished in the original container from the manufacturer. Medication to be stored as directed by school nursing staff in the nurse's office.
* If the dosage or time of medication changes, the physician must submit the new prescription on a signed form to school. A new labeled container from the pharmacy indicating the new dose/time is also required. (Also new parent request/signatures)
* Student has demonstrated to me that he/she/they understand(s) the proper use of this medication.
* I acknowledge that the school district may not incur liability as a result of any injury arising from the self-administration of medication by the pupil, and that I shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
* I understand that it is my responsibility to pick up any unused medication at the end of the school year, and that medication not picked up will be disposed of.
* I request that the principal or their designee allow my child to take the medication as directed above.
* I understand this form is valid during the current school year and summer school if needed.

Parent/Guardian Signature: _____ Date: _____

Telephone Number: _____
Home Work Cell/Emergency

NOTE: THIS PORTION OF THE FORM MUST BE FILLED OUT BY DOCTOR'S OFFICE: This must be completed and returned to the school annually prior to the student beginning self-administration of medication.

PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL

Medication will be taken by a student at school only when absolutely necessary. Whenever possible, schedule medication outside of school hours. The following medication/procedure has been prescribed by me and is necessary for this child to take/perform during school hours. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication/procedure on his/her/their own with school personnel supervision.

Med Name/Procedure	Dosage	Time	Diagnosis

Physician's Signature: _____Date: _____

Physician Name (Print): _____