School Year: _____

Self-Administration/Self-Possession of Medication

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate self-administration. Please complete this form if you want this student to self-administer and self-possess their medication while in school.

Student Name: _____DOB:_____ School: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN:

***Diagnosis for Medication:*_____**

Medication Name	Dose	Time To Be Given *If PRN please indicate how often medication can be given*	Route	Side Effects	Special Instructions (Such as "take with food")

Start Date: _____ Stop Date: _____

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: _____

_____ _____ _____

Physician Signature **Date** **Physician Printed Name**

To be completed by parent/guardian:

I am giving permission for my child_____ to: ☐ self-administer ☐ self-possess the above medication according to the school district policy and for the physician and school district staff to share information regarding my child's medication needs.

_____ _____

Parent/Guardian Signature Date

Please turn the completed and signed form into the main office when completed.

Updated 4/2023

School Year: _____

Student Name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled prescription or over the counter container
3. Take the medication only at the prescribed time, frequency and dose.
4. Carry a copy of this form with me and present it to the school staff if asked.

I understand if I do not comply with this agreement then the medication will be confiscated and returned to my parent/guardian and my privilege of self-administration/self- possession will be denied.

_____ _____

Student Signature Date

Please turn the completed and signed form into the main office when completed.

Updated 4/2023

School Year: _____

POLICY CONCERNING ADMINISTRATION OF

MEDICATIONS/MEDICAL PROCEDURES BY SCHOOL DISTRICT PERSONNEL

HOLD HARMLESS AND INDEMNIFICATION

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to _____ _____, as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board of Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities, demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties listed above or against any other person associated with the Southgate Community School District under any legal theory based upon or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures to _____.

Witnesses:

_____
Signature of Parent/Guardian

_____ _____
Telephone No. (Home)

_____ _____
Emergency Contact Name

Date

_____
Emergency Contact Number

_____

Please turn the completed and signed form into the main office when completed.

Updated 4/2023