# HUBER HEIGHTS CITY SCHOOLS

## Request for Student Possession or Self-Administration of Medication

Student Name _____ Date of Birth _____

School _____ Grade _____ Teacher (for K-6 only) _____

### Section A. Physician Information / Authorization (to be completed by student's physician).

Name of Medication _____

Form of Medication: ____ Tablet ____ Liquid ____ Inhaler ____ Injection

Dosage _____

Length of time student will need to carry this medication _____

It is my professional opinion that the above named student must carry the above named medication on his/her person while at school or at school-related activities because:

- The student's health or life is dependent on the immediate availability of the medication; and
- The student has the capability and maturity to self-administer the medication safely.

I understand that the student will not be supervised in the possession or administration of this medication.

The student will display the following symptoms when medication is needed. (Please provide a clear, non-technical description.)

_____

If school personnel are present and aware that student is in need of this medication, they should take the following action(s):

_____

If patient self-administers medication without needing it, what reactions/symptoms would be displayed, and what action(s) should be taken by school personnel? _____

What reactions/symptoms would be displayed if another student other than this student took this medication? What emergency action(s) should school personnel take in this situation? _____

_____

What other information should school personnel know regarding this medication and this patient? _____

_____

I certify that all of the information in Section A is true and accurate to the best of my knowledge, and represents all the necessary information school personnel need to know regarding this patient and this medication.

Physician Name (printed) _____ Phone _____

Physician Signature _____ Date _____ FAX _____

### Section B. Parent Authorization Section

We (I) understand the undersigned desire to request that our child be permitted to carry the above named medication on his person while under the supervision of the Board of Education of Huber Heights City Schools. We (I) understand that the Board reserves the right to refuse requests for supervised or unsupervised student medication when, in the opinion of the Superintendent, the proposed medical regimen imposes unusual risks upon the student or unusual practical or legal burdens on the school district or its staff.

We (I) assume all responsibilities regarding possession and administration of this medication by our child, and release Huber Heights City Schools, all of its staff, and agents from any and all liability resulting from harm to this student or others as a result of the student's possession or use of this medication, and indemnify each of them against any loss or expense incurred arising out of these arrangements, including any civil judgment which may be rendered against them. Furthermore, we (I) assume responsibility for all costs resulting from the need for medical transportation or treatment resulting from the student's health or medical condition.

Further, we (I) will notify the school immediately if we (I) change physicians, medication, or terminate use of medication for any reason.

Signature(s) of Legal Custodian(s): [Both parents or all persons/parties with legal custody of student must sign this form]

_____ Date _____

_____ Date _____