MT. LEBANON SCHOOL DISTRICT HEALTH SERVICES

Permission to Self-Carry and Self Administer Diabetic Medication/Supplies

Name:_____ Date:_____

In accordance with Pennsylvania State Law, I hereby agree to allow my child to carry their Diabetic Medication/Supplies. I acknowledge that Mt. Lebanon School District and its staff bear no responsibility for the benefits or consequences of the medication and that the school bears no responsibility for ensuring that the medication is taken.

I understand that my child must successfully complete the self administration form with the certified school nurse and have a current, completed medication form on file that states they are permitted to self carry and self administer the said medication.

The Mt. Lebanon School District reserves the right to withdraw permission at any time if the student is unable to demonstrate responsible behavior in carrying and/or taking this medication. If this should occur, the school will notify the parent/guardian of the said withdrawal of permission.

_____ _____

Parent/Guardian Name/Signature **Date**

I agree to be solely responsible for my diabetic Medication/Supplies and to follow the directions for its use as ordered by my licensed prescriber and the District's medication policy. I am aware that any abuse or misuse of this privilege will result in confiscation of the medication and loss of privilege to self carry and self administer this medication.

_____ _____

Student Signature **Date**

FOR CERTIFIED SCHOOL NURSE USE ONLY

Medication form completed and on file: Yes:_____ No:____

Student Self-Administer Assessment completed and on file:
Yes:_____ No:____

_____ _____

5/23;7/24 **Certified School Nurse Signature** **Date**