



THOMAS COUNTY SCHOOLS

Dr. Lisa Williams, Superintendent

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Written Authorization for Self-Administration of Medication by Minor Children at School

** A current, non-expired prescription and physician's signature must be provided with this documentation.*

**New form must be submitted each school year*

Student Name: _____

Date of Birth: _____ Grade: _____

Medication and Dose Student Will Self Carry: _____

Indications for Use: _____

I, _____, (Parent/Legal Guardian) of the above-named student hereby request authorization for self-administration and possession of asthma medication, epinephrine auto injector, or diabetic medication by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her medication.

I understand that:

1. The school district and its employees and agents shall incur no liability for:
 - a. any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; the student's use, misuse, overuse, or neglected or failed use of his or her medication; lost, misplaced, outdated, inaccessible, empty, or faulty medication and devices
 - b. the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with medication.
 - c. The school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff

I take sole responsibility for:

1. The monitoring of medication, medication use, and refilling of prescriptions for medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered medication.
2. Ensuring the student always carries his/her medication on his/her person.
3. Deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
4. Informing school nurse in writing of any changes in the student's treatment or management
5. Informing the school nurse of any exacerbations, hospital visits, and/or new or changed student medical information.

6. Informing the school nurse in writing of any medication side effects that warrant communication to the parent/guardian.
7. Coordinating distribution of the student's medical management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release Thomas County School System and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her medication.

Parent/Legal Guardian Signature

Date

I, _____, the above-named student have been instructed in the proper use of my prescription medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

Student's Signature

Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her medication. It is my professional opinion that the student be permitted to carry and self-administer his/her medication. I have provided the parent/guardian with a written emergency/management plan including the name, purpose, dosage, and administration directions of the medication.

Physician's Signature

Date