

Permission to Self-Carry Non-Controlled Prescription Medication at School

Student Name

Grade

Date of Birth

Name of Prescribing Healthcare Provider (HCP) with Prescriptive Authority

Provider Phone Number

Medication Name/Dosage/Frequency/Route

I _____ (parent/guardian name), request that my student named above be permitted to carry the medication listed on their person. I confirm my student is responsible, and they understand the following:

- ☐ The purpose of the medication
- ☐ The appropriate time, route, dose, and name of medication
- ☐ The medication cannot be used for any other use other than the prescribed and intended use and shall not be shared with any other individuals, including other students, and doing so would be a violation of CCSD Board Policies, including, but not limited to, CCSD Board Policy JICH, and may result in disciplinary consequences.
- ☐ When and where to seek adult guidance regarding the medication or symptoms they are experiencing prior to, or after the use of the medication
- ☐ Will notify me (parent/guardian) if they need a medication refill or the medication is not working

I, as the parent/guardian, absolve the school of any responsibility in safeguarding our students' medication. If the student demonstrates irresponsible behavior with this medication, the school will have full discretion to revoke this permission at any time.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

School Nurse Acknowledgement

- ☐ Medication order signed by provider with prescriptive authority is on file in the school health clinic
- ☐ Appropriate need-to-know school staff have been notified of the student's medical condition and the authorization to possess and self-administer this medication.
- ☐ The school nurse will keep all appropriate records associated with the student's self-administration plan
- ☐ The school nurse will verify.
 - The student's HCP agrees.
 - Date confirmed: _____ Via: _____ (e.g. phone, email, signed permission/order from provider)
 - The student has demonstrated correct technique for medication use and has evidenced an understanding of the health care provider's order for time of administration and appropriate dosage.

School Nurse Signature

School Nurse Printed Name

Date