



Permission for Student to Self-Monitor/ Self-Administer Medication/Procedure

Name:	DOB:	Grade:	Teacher:
Medication/Procedure (one per form):		Dosage:	Route:
Purpose of Medication/Procedure:	Frequency:	Allergies:	
Possible Side Effects:	Medical Diagnosis:	ICD-10:	

This student has been trained and is competent to self-monitor or self-administer medication or perform this procedure, and the student and parents are aware of the risks involved in over medicating and use by other students for whom this medication or procedure is not prescribed.

Signature of Physician:	Date:
Type or Print Name of Physician:	Office Phone: Office Fax:

Section below to be completed by parent/guardian and student:

I authorize that my child is competent to self-medicate or self-monitor as noted above in any area of the school or school grounds, at any school sponsored activity, in transit to and from school or school sponsored activities, and during before-school or after-school activities on school property. I give permission for the Registered Nurse to train assigned unlicensed staff members to assist with the medication/procedure as needed. I give permission for the school nurse or school administrator to contact the health care provider named above, the pharmacist who filled the prescription and/or their designated employees to discuss this medication/procedure and my child's health. I understand that my child must keep his/her medications in the original, labeled container. The container must have my child's name, the name and the dosage of the medication, and the directions for proper use on it. I also understand it is my responsibility to provide the medication/supplies that my child may need during school or school related activities. I understand that my child will lose the privilege to self-medicate or self-monitor if he/she endangers himself/herself or another student by misusing the medication(s). I also give permission for this "permission for self-monitor/self-administer medication" form to apply if I transfer my child to another school in this same school district during this same school year. I understand that permission will be granted on a year-by-year basis provided requirements in the District's policy JLCD and administrative rule JLCD-R and the requirements herein are met.

Your child may qualify for an Individualized Healthcare Plan (IHP). The school nurse will be writing this plan for your child based on medical orders. If you do not want your child to have an IHP, please contact your child's school nurse. If your child rides a bus and you would like the bus driver trained for this medication, please contact your child's school nurse.

The school district and its employees and agents are not liable for an injury arising from administration of medication authorized by an IHP. The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP.

I will not hold the school district or any of its employees or agents liable individually or on my child's behalf, if an injury occurs related to my child self-medicating or self-monitoring. I will be responsible for any costs related to any claims that occur arising out of my child self-medicating or self-monitoring and will hold harmless the district and its employees and agents for any such claims. I understand that permission will be granted on a year-by-year basis provided requirements are met.

Signature of Parent/Guardian:	Daytime Phone Number:	Date:
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I understand my responsibilities for self-monitoring or self-administration of the above prescribed medication or monitoring device. Furthermore, I understand that the medication or monitoring device is to be kept with me at all times and is not to be shared with other students.

Date: _____ Signature of Student: _____