EXHIBIT-5141.21 (a)

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM FOR SELF ADMINISTRATION/SELF POSESSION

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his or her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply for medication is to be carried. The school district recommends that spare medication, properly labeled in its origin container, be kept in the office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon notice to the parent/guardian.

Student Name: _____ Date of Birth: _____

Grade: _____ School Year: _____

To be completed by physician/licensed prescriber:

	Medication Name	**Dose**	**Time to be given**	**Form/Route**
1.				
2.				

Routes: oral (pill/capsule/chewable/liquid) – topical (eye drops, ointment) – injection - other

Administration of this medication is required for the treatment of the child's _____. I have instructed _____
(medical condition) (child's name)
on the proper method of the medication and am satisfied that he/she has the skill-level necessary to self-administer the medication and any device needed to administer it.

_____ _____

Physician's Signature Date

_____ _____

Printed Name Physician Phone Number

EXHIBIT-5141.21 (b)

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM FOR SELF ADMINISTRATION/SELF POSESSION

BY SIGNING THIS FORM, YOU AGREE TO RELEASE THE DISTRICT FORM ANY AND ALL LIABILITY THAT MAY RESULT FROM YOUR CHILD'S SELF-ADMINISTRATION OF MEDICATION.

To be completed by parent/guardian:

I, _____, request and give permission for
(parent/guardian)

_____ to receive
(name of child)

_____ in the manner prescribed by his/her
(name of medication)
physician in the attached medical authorization according to district policy and for the physician(s)/staff and school district to share information needed to assist my child with medication needs.

By signing this consent form, I agree to release, indemnify, hold harmless, and defend the school, its employees or agents from and against any and all claims, losses, damages, costs, actions, judgments, expenses and liabilities of every kind and nature whatsoever, that are in any way connected with, arise from, or are claimed to arise from, the self-administration or storage of my child's medication.

_____
Parent/Guardian (print name)

_____ _____
Signature Date

EXHIBIT-5141.21 (c)

STUDENT MEDICATION LOG

I give permission for Wrangell Public Schools to administer medication to my child. By signing this consent form, I agree to release, indemnify, hold harmless, and defend the school, its employees or agents from and against any and all claims, losses, damages, costs, actions, judgments, expenses and liabilities of every kind and nature whatsoever, that are in any way connected with, arise from, or are claimed to arise from, the administration or storage of my child's medication.

Student Name:_____ Name of Med:_____

Dosage:_____ Time:_____

Dates of permission for administration are from:_____to:_____

Parent/Guardian Signature:_____Date:_____

Principal Signature: _____ Date: _____

Date	Time	Administered by	Date	Time	Administered by

If the dosage is different than what is listed above, it must be noted on this form.

EXHIBIT-5141.21 (d)

STUDENT MEDICATION BINDER LOG

*Always label OTC medication with student name & dosage
* PRESCRIPTIONS must have student name, dosage and physician/contact information

Date	Student Name	Grade	Medication	Dose	PRSCB/OTC	Signature

Adopted in Consultation with Legal Counsel: October 17, 2005
Revised: March 17, 2025
Reviewed: November 19, 2025