NEGAUNEE PUBLIC SCHOOLS
MEDICATION SELF-ADMINISTRATION PLAN AND AUTHORIZATION

Student's Name_____DOB_____Grade/Teacher_____

Self-administration of prescribed inhalers for respiratory problems, medication for allergic reactions and insulin for diabetics will be allowed. All medications must be in the original container, clearly labeled, indicating the following information: student's name, name and dosage of mediation, method of administration, date issued, and doctors name.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child)_____ be allowed to self-administer the medication listed below at school according to school policy.

I understand that:

My child is responsible for administering his/her medication
It is my responsibility to notify the school of change or discontinuation of medications
The school is not responsible for determining the number of times the medication is used
If there is a misuse of the medication, it will be taken away from the student
I have the option of requesting school employees to administer the medication listed below in the presence of another adult

By authorizing self-administration of medication for my child, I waive the option of school employee administration and understand that the building administrator, teacher, or other school employees are not liable for my acts, or the acts of the child in self-administration of this medication.

Signature_____Relationship_____Date_____Phone_____

To be completed by the physician/authorized prescriber

Name of medication _____
Reason for medication _____
Form of medication/treatment (please circle) Tablet/Capsule Liquid Inhaler Injection Other
Instructions (schedule and does to be given at school)_____
Start date _____ End date _____

Restrictions/important side effects (please circle)
None Anticipated Yes, please describe _____

This student is both capable and responsible for self-administering this medication (please circle)
No Yes, supervised Yes, unsupervised

This student may carry this medication (please circle)
No Yes

Health Care Provider's Name _____
Address _____
Phone _____ Date _____

Physician signature _____