New York Mills Public Schools – District #553

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New York Mills, MN 56567
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Over-the-Counter Medication Self-Carry and Self-Administration Authorization Form

STUDENT: _____ DOB _____
School Year: _____ Grade: _____

ILLNESS/MEDICAL CONDITION BEING TREATED: _____
MEDICATION: _____
DOSE: _____ROUTE:_____
TIME/FREQUENCY: _____
CONTINUE UNTIL: _____

I have reviewed the medication with the student and the student's parents, and the medication may be Self-administered by the student during school hours.

SCHOOL NURSE_____ DATE_____
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The undersigned, as parent(s)/guardian of the above named student, request permission for, and hereby authorize, the student to self-administer the above named medication during school hours. Further, the undersigned acknowledge and understand the following:

1. Medication shall be maintained in the original prescription container with original label.

2. I understand that my child shall be permitted to carry the above noted medication as long as he/she does not endanger him/herself or other persons, and will not misuse the medication.

3. I understand that if my child misuses the medication, shares it with others, endangers others with this medication, school employees or agents may confiscate the medication and the self-carry privilege revoked.

4. School personnel may examine the medication container upon request, and any medications not maintained in the original container may be confiscated by school personnel.

5. The school may require the student to store the medication in a central location in the school.

6. The undersigned has reviewed the medication administration procedure with the student and believe student understands the administration procedure and is capable of self-administering the above medication.

7. The undersigned will notify the school immediately if the student's health status changes, or there is a change or cancellation of this medication.

8. School employees and personnel will not be involved in the administration of the above medication and will not be monitoring the student for side effects or student's failure to take the medication.

The undersigned and student shall be solely responsible to assure that the medication is taken responsibly.

PARENT/GUARDIAN: _____ DATE: _____

PHONE :(H) _____ (W) _____ (other) _____