CUSTER SCHOOL DISTRICT 16-1

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION FOR LIFE THREATENING CONDITIONS

Name of Student:_____ School Year:_____

School: _____Grade: _____ Start Date: _____ End Date:_____

Diagnosis: _____ Medication: _____

Strength: _____Dosage:_____ Frequency: _____Route: _____

I authorize this student's capability of self-administering this prescribed medication.

_____ Start Date: _____

Signature of Physician/Licensed Health Care Provider

I authorize my child to carry the above medication on his/her person at school, and to self-administer said medication as required, consistent with the directions provided by the prescribing physician. I understand the medication must be in the original pharmacy-labeled container stating the student's name, medication, provider, date of prescription, directions for use, and dose to be given. If my child uses the medication in a manner other than prescribed, my child may be subject to disciplinary action by the school. Further, I hereby specifically indemnify the school system and its employees from any harm, which may occur as a direct result of his/her self-administration of the above-cited medication.

Parent/guardian signature: _____ Date: _____

I authorize the Principle/designee of my child's school to administer the above prescription medication to my child if my child is unable to self-administer. I understand that it is recommended that my child who self-carries authorized emergency medication have a secondary emergency inhaler or anaphylaxis medication in the nurse's office for emergencies. Further, I hereby specifically indemnify the school system and its employees from any harm, which may occur as a direct result of the administration of the above-cited medication.

Parent/guardian signature: _____ Date: _____