USD 465 Winfield Public Schools
Permission for Self-Administration of Medication

Name of Student _____

School _____ Grade _____

Diagnosis _____

Medication _____ Dosage _____

Time(s) to be given at school_____

Comments _____

I hereby give my permission for my son/daughter to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I understand that this must be renewed annually.

My child has been instructed on self-administration of the medication and is authorized to do so in school.

Additional requirements

A student shall be denied the opportunity to self administer medications if:

1. the "Permission for Self-Administration of Medication" form has not been completed by the parent/guardian and the prescribing Health Care Provider.
2. a student does not follow proper administration of medications
3. a student fails to adequately secure medications at school
4. a student shares or attempts to share (a prescription) medication with another student
5. a student sells or attempts to sell (a prescription) medication to another student

_____ Date _____
Signature of Parent/Guardian

_____ Date _____
Signature of Health Care Provider
(Physician, ARNP, PA)