 **Permission to Self-Carry a Daily Dose of Prescription Medication at School**

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Student Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name/Dosage/Frequency/Route

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider with Prescriptive Authority License Number

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(parent/guardian name)

request that my student named above be permitted to carry medication on their person or keep medication in their backpack. I consider my student to be responsible and they understand the following:

* The purpose of the medication
* The appropriate time, route, dose, and name of medication
* The medication cannot be used for any other use other than the prescribed and intended use and shall not be shared with any other individuals, including other students, and doing so would be a violation of CCSD Board Polices including but not limited to CCSD Board Policy JICH, and may result in disciplinary consequences.
* When and where to seek adult guidance regarding the medication or symptoms they are experiencing prior to or after the use of the medication
* Notify me (parent/guardian) if my student needs a medication refill or the medication is not working

I, as the parent/guardian, absolve the school of any responsibility in safeguarding our student’s medication. If the student demonstrates irresponsible behavior with this medication, the school will have full discretion to revoke this permission at any time.

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Parent/Guardian Signature Date

School Nurse and Administrator Acknowledgement

* Appropriate school officials with a need to know have been notified of the student’s medical condition and the authorization to possess and self-administer medication.
* The school nurse will keep all appropriate records associated with the student’s self-administration of medication plans.
* The school nurse will verify that the student has demonstrated correct technique for medication use and has evidenced an understanding of the health care provider’s order for time of administration and appropriate dosage.

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School Administrator Date

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School Nurse Signature Date