Pleasant Hill R-III School District

Permission for Student to Carry and
Self-Administer Prescribed Medication

A MEDICATION AUTHORIZATION AND TREATMENT/EMERGENCY ACTION PLAN ARE ONLY VALID FOR THE CURRENT SCHOOL YEAR

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Physician: _____
School Year: _____

Students may carry and self-administer prescription medication while at school, school-sponsored event, or in transit to or from school **ONLY** if following requirement have been met:

1. A physician prescribed the medication for use by the Student and instructed the Student in the correct and responsible use of the medication.
2. The Student has demonstrated the skills necessary to use the medication and any device necessary to administer such medication to the Student's physician or physician's designee, and the school nurse.
3. The Student's physician has approved and signed a written treatment plan for managing the Student's chronic health condition, asthma or anaphylaxis episodes, and for medication to be used by the Student.
4. The Student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and liability statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the Student. Electronic signature upon enrollment will be accepted.

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER:

I certify that I am a licensed physician authorized by law to prescribe medication. ❒

I certify that I have prescribed or ordered the following medication _____ for the above named Student for the treatment/management of the following condition _____.

- ❑ I have instructed the Student in the correct and responsible use of the prescribed medication.
- ❑ I have attached a Treatment/Emergency Action Plan for managing the Student's condition (ex. asthma, seizure, anaphylaxis)

OR

- ❑ For Asthma **ONLY** - Student may follow School Provided Asthma Treatment Plan Orders Set. **Personal best or predicted: PEF _____**
- ❑ The Student is capable of self-administering the prescribed medication in accordance with the treatment plan and has demonstrated to me or my designee the skill level necessary to self-administer the medication.

_____ _____
Signature of Physician Date

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER:

I have acknowledged the following disclosures, by providing an electronic signature upon electronic enrollment to the Pleasant Hill School District.

- I have provided the Pleasant Hill School District with an updated medical history of the Student's condition, for which the medication prescribed, upon enrollment or other documentation.
- I understand that the District and its employees or agents may disclose information provided to administrators, school nurses, teachers and other school employees as may be necessary to protect the health and safety of the Student and to establish that the Student has been authorized to self-carry the medication. I understand the District and its employees or agents shall incur no liability for the disclosure of such information.
- I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medications by the Student, absent any negligence by the District, its employees or its agents. I shall indemnify and hold harmless the District and its employees or agent against any claims arising out of the self-administration of medication by the Student.
- I understand the Student will no longer be allowed to self-carry prescribed medication if found to be misusing the medication in any way.
- I understand that prescription medication will be kept in its original container displaying the Student's name and physician's prescription directions.
- I understand that I am ultimately responsible for the following:
    - Informing the school district immediately if any information provided on this form changes.
    - Informing the school if administration of medication should end.
    - Providing an appropriate Treatment/Emergency Action Plan.

_____ _____

Parent/Guardian Signature Date

For District Use Only
(To be Completed by School Nurse)

I have observed _____ (Student's Name) satisfactory demonstrate proper technique for self-administration of _____ (Name of Medication or Device).

The Student verbalized understanding that they will come to the health room immediately after use of an emergency medication. ❒

_____ _____

School Nurse Signature Date