WEST JASPER COUNTY SCHOOL DISTRICT
MEDICATION ADMINISTRATION FORM

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REQUEST FOR ASSISTANCE WITH SELF-ADMINISTRATION
OR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

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THE FOLLOWING SECTION TO BE COMPLETED BY THE PARENT:

Name of child:____Date of Birth_______________Grade:____

Name of Medicine:___________________________Dosage_______________Time___________

Parent's Name______________________ ________________Phone #_________________________

Initial one:____yes_____no____n/a: If your child uses an inhaler for asthma, can he/she be responsible to self-medicate (use the inhaler on his/her own discretion without the assistance of personnel?) If so, he/she will be allowed to carry the inhaler and it is recommended that a spare inhaler be kept in the nurse's office. If not able to use the inhaler on his/her own, the inhaler will be kept in the nurse's medicine box until needed. This applies to epi-pens also.

I/we understand that assistance in administering or self-administration medication cannot be given until a written doctor's order has been presented to the school. I/we understand that the parent/guardian is responsible for bringing the medication to school and students are **not allowed** to bring medication to school with the exception of self administered rescue inhalers. I/we understand the medication HAS TO BE in its pharmacy labeled bottle with the student's name, name of medicine, method of administration, time(s) to administer the medication, prescription number, name of pharmacy, date filled, and physician's name. I/we understand that it is the parent/guardian's responsibility to obtain written orders from the student's doctor regarding assisted medication administration or self-administration. I/we understand that if the dosage/method/time of administration is changed, the parent/guardian and the child's physician must complete a new permission form. I/we understand that unused/old medication has to be picked up by the parent/guardian. If not picked up within two weeks of nonuse, the medication will be discarded. I/we understand that no medication will be kept at the school over the summer break. If medication is not picked up prior to the last day of school, the medication will be discarded.

I/we request that personnel designated by the principal assist my child during school hours in taking the medicine(s) described below or I/we request that my child be permitted to self-administer the medication. I understand that the person that may be assisting my child to self administer medicine may not be a licensed medical or nursing professional and will not have to have medical or nursing training.

I/we forever release, discharge and covenant to hold harmless the West Jasper School District, its personnel and Board of Trustees from any and all claims, demands, damages, expenses, loss of services and causes of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss of damages of any kind resulting from the administration or assisted self-administration of the prescription medicine.

I/we agree to repay the West Jasper School District, its personnel or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any such injury to the minor child as a result of administration of the prescription medicine.

I/we have read the foregoing release and indemnity agreement and fully understand it.

Executed this the ___________day of _____________________, 20______.

_______________________________________ ____________________________________

Parent or Guardian Witness

The following section is to be completed by the PHYSICIAN:

IF THE CHILD MUST HAVE THE MEDICINE DURING SCHOOL HOURS, PLEASE SUPPLY THE FOLLOWING INFORMATION:

Diagnosis for which medication is given:____
Name of medicine_________________________________Dosage ____________ Route_________________
Time to give _______________ After Breakfast _______ After Lunch ________
Length of time to be taken____

Signature of Physician_____________________________________Date___________________________