The School District of the Chathams
School Health Services

SCHOOL DISTRICT OF THE CHATHAMS
Authorization for administration of medications during school hours
Valid for the school year _____ to _____

To be completed by the **Parent /Guardian**:

Child's Name_____ Date of Birth_____

Physician's Name_____ Physician's phone_____
Physician's Address_____

I request that my child be permitted to self- medicate as authorized by me and my child's physician. I understand that the School District of the Chathams shall incur no liability as a result of any injury arising from the self-medication by our child and that I indemnify and hold harmless the district and its employees against any claims arising out of the self–administration of medication by our child.

I understand that before my child will be permitted to self-administer their medication, I must provide the school nurse with an additional inhaler, epi pen or other device, which must be identical to the one that my child has been prescribed

Parent/Guardian Signature_____ Date_____

To be completed by the **Prescribing Physician or Advance Practice Nurse**
Please make a copy of this form for your records in accordance with FERPA and HIPPA laws

Diagnosis:_____
Medication_____Dose:_____ Form_____
Route_____
If medication is to be given daily, at what time?_____
If medication is PRN describe indications:_____
List significant side effects:_____
Length of time this treatment is recommended:_____
This pupil is physically fit to attend school and is free of contagious disease.
This pupil would not be able to attend school if the medication is not administered during school hours.

FOR SELF-ADMINISTRATION OF INHALERS AND EPI PENS
I authorize _____ to self-medicate as outlined above. This child is capable of and has been instructed on the proper method of self-administration.

Physician Signature_____Date_____Stamp_____