Smithton R-VI School District
Self-Administration of Medication Record

School Year_____

Students may carry and self-administer a daily dose of over-the-counter or prescription medication if a parent's written request on the authorization below is on file in the nurse's office. The medication must be in the original container.

Prescription medication that is to be taken for 2 weeks or less may be carried and self-administered by the student if arrangements are made in advance with the nurse. Only a daily dose may be carried and the medication must be in the pharmacy labeled container and prescribed to the student. Prescription medication taken on a daily basis for longer than 2 weeks will be kept in the nurse's office.

Student Name_____ Birth Date_____ Grade_____

Medication_____ _____mg Dose_____ Times_____

For treatment of_____ Date to begin_____ Date to end_____

Physician Name_____ Physician Phone #_____

Pharmacy _____Rx #_____

My child will be responsible for carrying and self-administering this medication. My child agrees to follow the school district's policy and procedure for carrying and self-administering medication. Failure to comply with the district's procedures will result in the loss of the privilege of carrying medication and may result in disciplinary action.

School personnel do not provide over-the-counter(OTC) medication for students at any time. All OTC medication must be provided by the parent or guardian.

Medication must be used in accordance with _____School District Policy.

Parent/guardian Signature_____ Date_____

Parents home phone_____ work_____ cell_____

The student must be able to state the name of the medication, correct dose, symptoms requiring medication, and correct timing of medication. Student agrees/understands they will not share medication with others and will keep medication in his/her personal belongings at all times.

Student Signature_____ Date_____

Student **does/does** not demonstrate meeting the requirements for carrying/self-administering this medication.
School Nurse Signature_____ Date_____