<u>STUDENTS</u> <u>Form</u> 2870.1

Student Services

Administering Medicines to Students

ACKNOWLEDGEMENT OF STUDENT SELF ADMINISTRATION OF MEDICATION

As parents/guardians of (Students Name) we authorize our son/daughter to possess and to self-administer medication to treat his/her chronic health condition.

We warrant that:

- 1. A licensed physician prescribed or ordered such medications for use by our son/daughter.
- 2. A licensed physician has instructed our son/daughter in the correct and responsible use of such medications.
- 3. Our son/daughter has demonstrated to our son/daughter's licensed physician or licensed designee the skill necessary to use the medication and any device necessary to administer such medications.
- 4. Our son/daughter's physician has approved and signed a written treatment plan for managing our son/daughter's chronic health condition that describes the specific medications to be self-administered and the medication's appropriate use by our son/daughter. The treatment plan includes a physician's statement that our son/daughter is capable of self-administering the medication under the treatment plan. A copy of this treatment plan is attached to this acknowledgement.

5.	We agree to complet the school.	e and submit	to the	school	any	written	documentation	required	ָל
	Parent/Guardian Sig	nature					Da	ate	

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WE ACKNOWLEDGE THAT THE SCHOOL DISTRICT	AND ITS EMPLOYEES SHALL
INCURE NO LIABILITY AS RESULT OF ANY INJURY	Y ARRISING FROM THE SELF-
ADMINISTRATION OF MEDICATION BY OUR SON/D	DAUGHTER OR ANY ADVERSE
EFFECTS OR INJURY CAUSED BY THE MEDICAT	TON AS ADMINISTERED BY
SCHOOL STAFF. HOWEVER, WE ALSO ACKNOW	WLEDGE THAT THE ABOVE
STATEMENT SHALL NOT BE CONSTRUED AS A RE	ELEASE FROM LIABILITY FOR
NEGLIGENCE.	
Parent/Guardian Signature	Date