Student Services

Permission to Self-Administer Medication

PERMISSION FORM
FOR STUDENT TO SELF-ADMINISTER MEDICATION

I hereby certify as follows:

I, _____ , the parent/guardian of
Parent/Guardian

_____, a student in the
Student

_____, am legally authorized
School District

to make educational and health care decisions for the Student.

I hereby give my permission for the Student to retain in his/her possession _____ and to self-administer this medication in accordance with my son/daughter's written treatment plan signed by his/her physician. This permission shall be effective during the school day, on school property, including but not limited to a school bus, and at all school activities, whether on or off school property or occurring during the regular school day.

I have provided the District with a written medical history of the Student's experience with his/her chronic health condition, ("Condition") and a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having the Condition.

I have provided the District with a copy of the Student's treatment plan including a physician's statement that our the Student is capable of self-administering the medication under the treatment plan, and written certification from the Student's physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self-administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.

I understand that the District and its employees or agents may disclose information provided in accordance the foregoing paragraphs to administrators, schools nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer the medication designated above, and 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 medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student. I understand that this paragraph shall not be construed as a release from liability for negligence.

I understand that this permission form is effective for the school year for which it is granted, and that a new Permission Form and supporting documentation as described above must be submitted for each school year.

_____ _____
Signature of Parent/Guardian Date

STATE OF MISSOURI)
)SS
COUNTY OF)

On this ____day of 20____, before me appeared _____ to me personally known, who, being by me duly sworn, did say that he/she executed the foregoing instrument and acknowledge said instrument to be his/her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year first above written.

_____
Notary Public

My commission expires: _____

OR

_____
Signature of nurse, secretary or administrator

