

University School**Authorization to Assist with Self-Administration of Medication**

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to bring this medication to school and remove any unused medication when treatment is completed. *A separate form for each medication to be administered must be completed.*

All prescription medication must be brought to school in the original container. The pharmacy label must include the following:

- Name of student
- Prescription number
- Name of medication and dosage
- Administration route or other directions
- Date
- Licensed prescriber's name
- Pharmacy name, address and phone number

All non-prescription or Over-the-Counter (OTC) medication must be brought to school in the original container manufacturer's labeled container with the ingredients listed and the child's name affixed to the container. The OTC medication should have legible expiration date and should not be expired. Expired medications are unable to be administered. Herbal/homeopathic medication shall be administered only with a physician's order and a completed medication form signed by the parent.

No more than one month's supply of any medication should be brought to school.

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Parent/Guardian Authorization

Student's Name

DOB

Grade

Allergies

I request that school personnel assist the above named student to self-administer the following medication while in school and away from school for school activities.

Name of Medication: _____ Amount to be taken: _____

Medication to be taken: orally topically inhalation injection

Time to be taken while at school: _____ Date of last dose to be taken: _____

Reason medication is needed at school: _____

Possible Side Effects of medication: _____

Date: _____ Name of Physician: _____

Parent/Guardian understands that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any person employed by University School/ETSU the undersigned parent/guardian hereby agrees to release University School/ETSU and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. **The Parent/Guardian will assume full responsibility for any side effects and complications that the child may have as a result of taking this medication.**

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Contact Number: _____