Washington County Department of Education
University School
Phone:(423) 439-8674 Fax:(423) 439-5921

AUTHORIZATION TO ASSIST COMPETENT STUDENT 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.

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

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 medication must be brought to school in the original manufacturer's labeled container with the ingredients listed and the child's name affixed to the container. **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.

PARENT/GUARDIAN AUTHORIZATION

_____ _____ _____
Student's Name School Date

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 of Medication to be taken:_____

How medication is to be taken (orally, topically, inhalation, injection):_____

Time(s) medication is to be taken:_____Date the last dose of this medication is to be taken:_____

Reason medication is needed at school:_____

Possible Side Effects of medication:_____

Date:___/___/___ Name of Physician_____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by Washington County School System, the undersigned parent/guardian hereby agrees to release the Washington County School System 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. **I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.**

Parent/Guardian Signature_____Date_____

Parent/Guardian Address_____

Parent/Guardian Name_____Home Phone #_____Work Phone #_____

Comments:____