MEDICATION/TREATMENT
CONSENT FORM FOR SELF-ADMINISTRATION

ROMEO COMMUNITY SCHOOLS

Student Name _____ **Birth Date** _____ **School Year** _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for their student to self-administer and possess a medication or treatment.
- Self-administration medictions include inhalers, epipens, glucagon and selected over the counter medictions. *Students may not possess or administer a controlled substance under any circumstance.*
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form in Part 2.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container only with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Metered dose inhalers must have a label attached to the container. Parents will notify the school immediately if there is a change in the use of the medication of the prescribed treatment.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required for student to possess and self-carry treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent and physician must sign below—Part 2.
- Any misuse of medication by a student, including selling or giving away the medication, violates school district policy that will result in revocation of self-administration privileges and may result in a referral to law enforcement officials. Please see the student handbook for policies regarding medication at school.

PART I: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

All Language/Directions must be in lay terms

TREATMENT/MEDICATION	DOSAGE	ROUTE	TIME	FREQUENCY

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

_____

_____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission for student to self-administer and possess health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care. *Please Note: School personnel will not supervise the medication administration or have responsibility in the process. Parent will be notified of any observed violation of the above guidelines.*

Physician/Provider:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

Parent/Guardian:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

Student:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____