

Emerson Waldorf School
MEDICATION AUTHORIZATION FOR SELF-ADMINISTRATION
2009-10

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name: _____ **Date of Birth:** ___/___/___

Medication: _____ **Dosage:** _____ **Route:** _____ **Frequency:** _____

Time(s) medication is to be given: _____ **Dates to be given from:** ___/___/___ to ___/___/___

(Medication request will be in effect through the end of the school year).

Condition: _____

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effects, adverse & omission reactions): _____

Contraindications for Administration: _____

This medication will be furnished by parent / guardian in a container properly labeled by a pharmacist with identifying information (i.e. name of child, medication dispensed, dosage prescribed and the time to be given).

Physician's Signature: _____ **Telephone:** _____ **Date:** ___/___/___

The above student has a medical condition that requires self-medication at school. I have reviewed the self-administration protocol and agree that this student has the knowledge and maturity to self-manage his/her medication safely and correctly.

I agree that my son/daughter named above has sufficient maturity and knowledge to use the above prescribed medication safely and correctly.

I understand that:

- the only liability which the school can assume is to comply with terms of this protocol
- the school can assume no liability for monitoring the self-administration, including the frequency and dose or the failure to self-medicate when necessary
- my son/daughter must comply with the procedures outlined on this form

Parent Signature: _____ **Date:** ___/___/___

I agree that I have sufficient maturity and knowledge to use the medication named above safely and correctly. I agree to:

- keep medication in my possession at all times and not leave it in a place accessible to other students
- not allow or offer any use to other students
- use medication in a responsible manner, in accordance with my physician's orders
- notify the school office or school nurse if I am having more difficulty than usual with my health condition

Student Signature: _____ **Date:** ___/___/___