**Parental Statement Regarding Student Self-Administration of Medication at School**

**For secondary students only (grades 6-12)**

**STUDENT INFORMATION:**

School Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_

Parent Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication(s) and dosage (s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ As per section 2.4.2 of the WCSD Medication Policy 2320, I authorize my child to carry and self-administer one dose of an easily identified prescription medication, or non-prescription over-the-counter medication, with the exception of syrups (typically used to treat coughs or colds), see medication(s) and dosage(s) above.

□ I acknowledge it is medically appropriate for my child to self-administer; that my child is responsible for, and capable of, self-administering and having the medication in his/her possession at all times, or I may make arrangements with the school to store the medication. (*A UDOH or WCSD Medication Administration Authorization form is not necessary*).

**This form may not be used for asthma inhalers, diabetes medication, epinephrine auto-injectors, seizure rescue medications or narcotics** (as per WCSD Medication Policy 2320).

□ My child and I understand there are serious consequences for sharing any medication with others.

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

(School nurse signature)