Northern Bedford County School District

Office of the School Nurse
Starla J. Snyder, MSN, RN, NCSN

AUTHORIZATION FOR SELF-ADMINISTRATION OF EMERGENCY MEDICATION

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Student Name Grade

To self-medicate, the student must be able to (check all that apply):

_____1. Respond to and visually recognize his/her name.

_____2. Identify his/her medication.

_____3. Demonstrate the proper technique for self-administering his/her medication.

_____4. Sign his/her medication sheet to acknowledge having taken the medication, if required.

_____5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

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Name of Medication/Dosage/Route/Frequency

The above student has demonstrated the ability to self-administer the physician-prescribed emergency medication, as indicated by the criteria listed above.

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Signature of Certified School Nurse Date

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication, when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will results in the immediate confiscation and loss of privilege to self-administer.

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Signature of Parent/Guardian Date

I agree to be solely responsible for my emergency medication and to follow the directions for its use, as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my mediation.

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Signature of Student Date