

# St. Patrick's School

## Student Medication Self Administration

### For inhalers and insulin

\_\_\_\_\_ (student name) will be keeping his/her medication and related supplies with him/her at school rather than in the school health office. \_\_\_\_\_ (student name) has been instructed in the proper use of \_\_\_\_\_ (this medication and the related supplies). The child's well-being is in jeopardy unless the medication and supplies are carried on his/her person; therefore, we request that he/she be permitted to carry the medication and supplies. He/she understands the purpose, appropriate method, and frequency of use of this medication and supplies.

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I plan to keep my \_\_\_\_\_ (medication) with me at school rather than in the school health office. I agree to use my medication in a responsible manner, in accordance with my physician's orders. I will not allow any other person to use my medication. I will notify school personnel immediately if I am having any difficulty with my asthma/diabetes. I understand that if I use my medication other than as prescribed I will no longer be allowed to keep the medication with me and it may result in disciplinary action.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

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I permit my child \_\_\_\_\_ (student name) to carry the above listed medication and related supplies as ordered by his/her physician. I understand that if my child uses his/her medication other than as prescribed or shares the medication or related supplies with other students, the school staff has the right to prohibit my child from possessing the medication or related supply. My child will then have access to the medication or supply only via the school office. In addition the student may be subject to disciplinary action.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

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I understand that my patient \_\_\_\_\_ (student name), will be carrying their own medication, as listed above, with him/her at school

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Route \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name Printed \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

**This form must be completed in addition to the Medication Authorization Form.**

# **Release and Indemnification Agreement**

(Self-Administration of Prescription Asthma, Anaphylaxis, or Diabetic Medication)

\_\_\_\_\_ (Parent/Guardian Name) hereby acknowledge that

St. Patrick's Catholic School employees and staff are not liable for any

Injury or death arising out of the self-management by

\_\_\_\_\_ (student name) of his/her asthma, anaphylaxis, or

diabetic condition. I hereby indemnify and hold St. Patrick's employees and

staff from any claim arising from the student's self-management. In the

event that \_\_\_\_\_ (student name) injures school personnel or

another student as a result of misuse of the prescription medication or related

medical supplies, the undersigned shall be responsible for any and all costs

associated with the injury.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature