Shepherd School
Parent Consent for STUDENT SELF-ADMINISTRATION of MEDICATION

Name of Child:_____DOB_____School: _____Grade_____

Diagnosis:	MEDICATION:	Time:	Dosage:	Start Date: _____ End Date: _____	Name of Physician:
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*The initial dose must be given at home.
*Medication must be furnished in a current original pharmacy container with student's name, name of medication, strength, and dosage to be given. Non- prescription medication must be furnished in the original container from the manufacturer.
*If the dosage or time of medication changes, the physician must submit the new prescription on a signed form to school. A new labeled container from the pharmacy indicating the new dose/time is also required. (Also new parent request/signatures)
*Student has demonstrated to me that he/she understands the proper use of this medication.
*I acknowledge that the school district may not incur liability as a result of any injury arising form the self-administration of medication by the pupil and that I shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
*I understand that it is my responsibility to pick up any unused medication at the end of the school year, and that medication not picked up will be disposed of.
*I request that the principal or his/her designee allow my child to take the medication as directed above.

Parent / Guardian Signature:_____DATE:_____

Telephone Number:_____
Home Work Cell/Emergency

NOTE THIS PORTION OF THE FORM MUST BE FILLED OUT BY DOCTOR'S OFFICE: this must be completed and returned to the school prior to the student beginning self-medication.

PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL

Medication will be taken by a student at school **only when absolutely necessary.** Whenever possible, schedule medication outside of school hours. The following medication/procedure has been prescribed by me and is necessary for (Child's Name) _____ to take during schools hours.

Med Name	Dosage	Time	Diagnosis	Physician

I certify that valid health reasons exist requiring said student have the medication during school hours. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision.

Physician's Signature:_____Date:_____