Dysart Schools

Parental Consent for Self- Administration of Medication

Student Name: _____ DOB: _____

School: _____ Grade: _____ Date: _____

Medication Name: _____

Medication Strength: _____ Amount to Given: _____

Time(s) to be Given: _____

Route to be Given (by mouth, inhaled, etc.): _____ Medication Expiration Date: _____

Reason for Medication: _____

My child has my permission to carry the above medication on his/her person or in a backpack as I consider him responsible. The student understands the purpose, appropriate method and frequency of use of the medication. The student will not share medication with other students.

I understand that prescription medication must be in the original container with the label intact, including the student name, medication name, dosage, and time to be given. An over-the-counter medication must be labeled with the student's name and in the original packaging, with all the directions, dosages, compound contents, and proportions clearly marked. Student misuse of self-administered medication may result in seizure and disciplinary action.

A signed physician's statement indicating the necessity is required for self-administration of medicine, whether it is prescription or over-the-counter medicine except in the case of medicine for diagnosed anaphylaxis and breathing disorders requiring handheld inhaler devices. In these cases, the student's name on the prescription label is sufficient for the physician's recommendations.

Parents accept full responsibility and liability for their student's actions in regard to use of medication at school and school functions.

I understand and agree that in the event of a medication related emergency, 911 (Emergency Medical Services) will be called if parents/legal guardians or approved emergency contacts are unavailable by telephone.

_____ _____ _____

Parent/Legal Guardian Name Parent / Legal Guardian Signature Date

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Physician Information

I _____ have instructed the above-named student/patient in the proper use of (medication)_____. It is my professional opinion that the student/patient be allowed to carry and use noted medication by him/herself.

Physician Signature: _____ Date: _____

Stamp here

This form may be printed, signed and brought to school, or
Saved and sent to school with electronic signature. Updated July 2022