Williamson County Schools
AUTHORIZATION TO ASSIST COMPETENT STUDENTS
WITH SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Dear Parent(s)/Guardian(s),

The self-administration of prescription medication by students can only be done if you understand the information below, provide your physician's authorization, and your written consent. Thank you for your cooperation.

1. Prescription medication can only be self-administered at school when it is required to maintain the health of the student.
2. Medication must be brought to school and delivered to the school nurse or designated school employee by the parent/guardian or their designated adult, for the student for whom it was prescribed. It must be in the original container, exactly matching the physician's order, and labeled by the pharmacy to include the following:
   a. Name of student
   b. Name of physician
   c. Name of medicine
   d. Instructions as to dosage, amounts, exact time, and route.
3. The student is allowed to carry a prescribed, metered dosage, asthma-reliever inhaler when at school, at a school-sponsored activity, or before or after normal school activities while on school property, including school-sponsored child care or before or afterschool programs with both parent and physician signature below.
4. The first dose of medication will be given at home in case of an adverse reaction to the medication.

________________________ ____________ ______ ____________ _________________
Student's Name **School** **Grade** **Date of Birth** **Medication Allergies**

__________________________ _________________ **To be administered at ____________**
Name of Medication **Dosage and Route** **Time**

PARENT/GUARDIAN PERMISSION:
I acknowledge that the above named student is competent to self- administer this medication with the assistance from the nurse or designated school employee while in attendance at school. I give permission for my child to self-administer this medication with the supervision of a designated school employee. I grant the school nurse permission, as necessary, to discuss the prescribed medication with the below named physician. I agree that Williamson County Board of Education shall incur no liability and be held harmless against any claims related to the administration of such medication, and if for a prescribed inhaler, the possession of it by the above named student. I give permission for my health care provider and Williamson County Schools to send or receive a fax of this medical record.

__________________________________ _____________ ______________ _______________
Name of parent/guardian **Home#** **Cell #** **Work #**

_______________________________________ ______ ____________________ _____________________
Signature of parent or guardian **Date** **email** **address**

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REQUIRED FOR PRESCRIPTION MEDICATIONS ADMINISTERED MORE THAN ONE WEEK
PHYSICIAN'S AUTHORIZATION FOR SELF ADMINISTRATION **(To be completed by physician)**
The above named student is under my medical supervision.
Reason for medication to be administered at school:____
Possible reactions/side effects:____
Special instructions for storage/handling:____
Child may carry Inhaler on self or in book bag ____
Name of Physician:__________________________________ Date prescription expires_______________

_____________________________________ _________________ ______________
Signature of Physician **Title** **Date**

____ ________________ _______________
Address **Phone #** **Fax #**