mesa PUBLIC SCHOOLS	TITLE: Consent for Student Self-Administration of Medication or Dietary Supplement at School
	FORM: JHCD-R-F(3) Updated 7/27/2020

Physician's Authorization

I authorize and recommend that my patient identified below (and referred to as the "Child") be permitted to carry and self-administer at school the medication/dietary supplement described below (and referred to as the "Medication"). In my opinion, the Child is sufficiently mature and reliable to self-administer the Medication. While I am aware that administration of medication by a school nurse is available as an option, I authorize and recommend that the Child be permitted to self-administer the Medication during school hours because:

_____

Child's name: _____ Child's age: _____

Medication/Dietary Supplement: _____ Dose: _____

Time to be taken at school: _____ Dates: From _____ to _____

Diagnosis/reason for giving: _____

Physician's name (please print): _____ Physician's Phone: _____

Physician's signature: _____ Date: _____

Parent's Authorization and Release

As the parent/guardian, I give permission for my child identified above (and referred to as my "Child") to carry and self-administer the medication/dietary supplement described above (and referred to as the "Medication") on his/her person, as authorized and recommended by the physician. **I understand that the Medication will be in the original bottle, written authorization will be carried with the Medication, and the amount carried is limited to no more than one day's dosage. Failure to comply with these requirements will result in immediate withdrawal of the privilege.**

As the parent/guardian, I believe that my Child has sufficient maturity to self-administer the Medication as directed by the physician and want my Child to exercise this privilege even though my Child could receive doses at scheduled times from the school nurse or health assistant. I release and discharge the District and its employees from any and all liability arising from my child failing to take his/her Medication as directed by the physician. I will direct my child to not share the Medication with any other student and accept responsibility if my Child causes harm to another student by such misconduct. Further, I authorize the school nurse or health assistant to discuss my child's prescription for the Medication with my Child's physician as necessary to understand the physician's recommendation.

NOTE: A student who is authorized to carry and self-administer a medication or dietary supplement will not distribute the substance to another student while on school property or traveling between school and home. A student who violates this policy will be subject to disciplinary action.

Signatures

Parent/Guardian: _____ Student: _____

Nurse: _____ Principal: _____

Effective Date: _____