Jefferson Joint School District #251
Every Student Can Learn and Succeed
3850 E 300 N
Rigby, ID 83442
(208) 745-6693 / (208) 745-0848 (fax)

Authorization for Self- Administration of Non-Prescription and Prescription Drugs

Student's Name: _____ Grade: _____ DOB: _____
Parent/Guardian Name: _____
Telephone: (Home) _____ (Work) _____

Indemnification/Hold Harmless Agreement For Self-Administration of Medication

The parent(s)/guardians(s) agree to indemnify, defend, and hold the School District harmless from any and all claims, actions, costs, expenses, damages, and liabilities, including attorney's fees, arising out of, connected with, or resulting from the self-administration of medication by the pupil. The parent(s)/guardians(s) agree(s) that the School District, Board of Education, Board of Education employees and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil. Specifically, the parent(s)/guardian(s) agree that they will not institute either on their own behalf or on behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect prior to the granting of permission to self-administer medication.

_____	_____	_____
Parent/Guardian's Printed Name	**Parent/Guardian's Signature**	**Date**

Disposal of Medication

School authorities will notify Parent/Guardian at the end of each school year to pick up remaining medicine. Medicine which is not repossessed by the parent/guardian within a seven day period of notification by school authorities will be destroyed by the school nurse in the presence of a witness.

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN FOR PRESCRIPTION MEDICATION:

I am recommending that the above named student be allowed to self-administer the following medication:

Name of Medication: _____ Purpose of Medication: _____

Identification of Chronic Medical Problem: _____

Prescribed Dosage, Frequency and Route: _____

Length of Time Medication is Prescribed: _____

Possible Side-Effects and/or Special Precautions to be taken: _____

Actions to take in the event of an emergency, including if the medication does not improve _____

_____

Conditions Under Which Self-Medication Will Take Place:

_____ **Independently** (*Child must have had training and be proficient in self-administering medication.*)

Trainer's Name: _____

Date of Training: _____

_____ **Under the supervision of a school nurse or designated staff**

Medication should be: _____Stored in office _____In possession of the student

_____	_____	_____	_____
Physician Name (print)	**Physician's signature**	**Date**	**Physician Phone #**

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT/GUARDIAN FOR NONPRESCRIPTION (OVER THE COUNTER) MEDICATION:

The above named student may be allowed to self-administer the following medication:

Name of Medication: _____ Purpose of Medication: _____

Identification of Chronic Medical Problem: _____

Prescribed Dosage, Frequency and Route: _____

Length of Time Medication is Prescribed: _____

Possible Side-Effects and/or Special Precautions to be taken: _____

Actions to take in the event of an emergency, including if the medication does not improve _____

_____

Conditions Under Which Self-Medication Will Take Place:

_____ **Independently** (*Child must have had training and be proficient in self-administering medication.*)

Trainer's Name: _____

Date of Training: _____

_____ **Under the supervision of a school nurse or designated staff**

Medication should be: _____Stored in office _____In possession of the student

_____	_____	_____
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**

A separate form is required for each medication