WALTON COUNTY PUBLIC SCHOOLS

Authorization for Self-Administration of ________________ Medication by Student

Student Name: ______________________________ Date of Birth: _______ Grade: ____________

As parent/guardian of the above-named student, I authorize the self-administration, and possession of ____________ ____________ medication at school, at any school-sponsored activity, while under the supervision of school personnel, and while in before-school or after-school care on school operated property. I understand that the student must demonstrate a full understanding of the proper use of his/her ________________________ medication.

- I understand that the school may choose to require supervision of medication administration in the event the student does not demonstrate appropriate use or proper technique with the administration of ________________ medication.
- I understand that the student is subject to the Code of Conduct or other student discipline for inappropriate behavior in connection with the possession, use and/or administration of medication.
- I understand that I am responsible for monitoring the student's medication, medication use, and refilling of prescriptions, and further understand that the school will not be responsible for supervising, recording or monitoring the self-administration of medication.
- I understand that I am responsible for the student's carrying his/her medication on his/her person.
- I understand that I am responsible for informing the school in writing of any changes to the student's treatment or medication management plan or regimen.
- I understand that I am responsible for deciding if back-up medication will be kept at school and for providing the school with such back-up medication.
- I understand that I am responsible for informing school staff in writing of any medication side effects.
- I understand that I am required to provide the school with a copy of the ________________ emergency/management plan written by the student's physician.

I have reviewed, and I understand and agree with the conditions, of Board Policy JGCD and JGCD-R regarding administration of medication. I authorize the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I release, and covenant not to sue, the Walton County School District, and its employees, from liability in connection with any claims arising out of the above-named student's possession and self-administration of his/her medication.

______________________________________ ______________________

Parent/Guardian Signature Date

I have been instructed in the proper use of my prescription medication and fully understand how and when to use it. I will carry my medication on me at all times and will not allow another student or individual to use it under any circumstance. I have reviewed, understand and agree to the terms of Board Policy JGCD and JGCD-R.

______________________________________ ______________________

Student's Signature Date

The above-named student has been instructed on, and demonstrates understanding of, the proper use of his/her medication. It is my professional opinion that the student should be permitted to carry and self-administer his/her medication. I have provided the parent/guardian with a written ______________ emergency management plan including the name, purpose, dosage, and administration directions for this medication.

______________________________________ ______________________

Healthcare Provider Signature Date