



## **SELF ADMINISTRATION OF MEDICATION CONSENT FORM**

### **Walnut Creek School District**

Dear Parent/Guardian,

Students who require the administration of medication during the school day pursuant to a physician's prescription and wish to self carry and self administer medication, must have a Self-Administration of Prescribed Medication consent form on file at the school site. This form must be completely filled out annually and signed by the parent/guardian and the child's physician before the child can carry and administer medication while on the school grounds.

In signing the Self-Administration of Prescribed Medication consent form, the parent/guardian agrees to release from liability the District, its officers, employees and agents for any loss, damage, injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the District, its officers, employees and agents related to the self-administration of medication by your child.

If your child has asthma, it is extremely important for you to fill out the Asthma Action Plan. It is in your child's best interest to follow the same plan of care at home and at school so that their asthma is under control and they can participate fully in all activities. If you have any questions, please contact the school office.



# SELF ADMINISTRATION OF MEDICATION CONSENT FORM

## Walnut Creek School District

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

School: \_\_\_\_\_

School Year: \_\_\_\_\_

### To be completed by the PHYSICIAN / AUTHORIZED HEALTH CARE PROVIDER

MEDICATION	ROUTE	DOSE	TIME/FREQUENCY	INDICATION

The child named above is under my care and it is necessary for him/her to receive the following medication during school hours. I agree that he/she can carry the medication and self administer it.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (please print): \_\_\_\_\_

Office Telephone #: \_\_\_\_\_ Fax

#: \_\_\_\_\_

### To be completed by PARENT/GUARDIAN

I understand and agree to the following:

1. To assume responsibility for sending my child's medication in its original prescription container.
2. To make certain that my child takes responsibility for taking the medication as prescribed and keeping medication away from other students.

I also agree that the District and its employees shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the District and its employees related to the self-administered medication by my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

