WEST SHORE CHRISTIAN ACADEMY

201 West Main Street
Shiremanstown, PA 17011
717.737.3550 (phone)
717.761.3977 (fax)

Authorization and Permission for Self-Administration of Medications

Please Check Appropriate Box: ☐ Asthma Inhaler ☐ Epinephrine Auto-injector

Name _____ Date _____

School _____ Grade _____ DOB _____

To self-medicate the student must:

- ☐ Respond to and visually recognize his/her name
- ☐ Identify his/her medication
- ☐ Demonstrate proper technique for self-administration of the medication
- ☐ Comply with the orders listed on the emergency action plan
- ☐ Notify the school nurse right away when self administration has occurred
- ☐ Store medication safely in a secure location

It is my professional opinion that this student should be permitted to carry and self-administer his/her medication in accordance to the orders prescribed on the emergency action plan.

Physician Signature _____ Date _____

I understand and agree to the conditions of the school policy regarding self-administration of medication. I give authorization for self administration and possession of the ordered medication by my child while at school, at school sponsored activities, while under the supervision of school personnel, and while in before or after school care on school property. My child demonstrates a full understanding of the proper use of this medication. I am responsible for: monitoring the medication use, supplying the medication, ensuring that the student always carries the medication, keeping it secured from others, deciding if back-up medication will be kept at school, providing the school with back-up medication, informing the school of changes in treatment of medical condition, and informing the school of side effects. I consent for the physician to release information about my child related to this medication. I release the school district and its employees of any legal responsibility related to my child's possession and self administration of this medication. I further acknowledge that he school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use, sharing of the medication or violation of the medication policy will result in immediate confiscation and loss of the privilege to self administer.

Parent/Guardian Signature _____ Date _____

I understand and agree to follow the school district's policy for self administration of my medication at school. I will be responsible for carrying the medication and not allowing another student to use my medication under any circumstances. I am aware that any abuse of this privilege will result in the confiscation of my medication.

Student Signature _____ Date _____

The above named student has demonstrated the ability to self-administer the medication according to licensed provider's orders as indicated by the criteria listed above

School Nurse Signature_____ _ Date _____

This authorization is good for one school year and will need to be renewed each year.
This form is in compliance with district policy 210.