CHENANGO FORKS CENTRAL SCHOOLS

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SELF-MEDICATION RELEASE FORM

For administration of medication at school & after school activities

Child's Name:____**Date:**____________________

has been instructed in the proper use of the following medication procedures:____________________________

____

We (Physician's signature)____

and (Parent or Guardian's signature)____

request that **(Child's name)**________________________________be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Student Responsibilities for Carrying and Using Medication Observed:

Except for inhalers, all medication must be kept in the Nurse's Office.

Yes	No	
_____	_____	Student is consistently able to: identify the correct medication; identify the purpose of the medication; know the correct dosage; identify the time the medication is needed; describe what will happen if medication is not taken.
_____	_____	Student demonstrates the correct use/administration.
_____	_____	Student does not share medication with others.
_____	_____	Student will keep medication in agreed location:______________________________
_____	_____	Student will come directly to the Health Office if any of the following symptoms occur:______________________________
_____	_____	Student keeps a second labeled container in the Health Office.

The student does/does not demonstrate the specified responsibilities. The student may/may not carry his/her medication. If the student does not follow the above agreement, the privilege of carrying and using his/her medication will be rescinded.

____
(Physician Signature/Date)

____
(School Nurse Signature/Date)

____
(Student Signature/Date)