CEDAR FALLS COMMUNITY SCHOOLS
SELF MEDICATION ADMINISTRATION CONSENT

School_____ Date_____

Student Name_____Birthday_____
In order for a student to self-administer medication requirements are:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- Physician provides written authorization containing:
  Purpose of the medication
  Prescribed dosage
  Administration time/s
  Special circumstances under which the medication is to be administered
- The medication must be in the original container either as dispensed by the pharmacist or the manufacturer's label. Must be labeled with student name, name of medication, directions for use and the date.
- Authorization is renewed annually. If any changes occur in the medication, dosage, or time of administration the parent is to notify the school officials immediately.

Provided the above requirements are fulfilled, a student may possess and use the student's medication while in school, at school-sponsored activities, and before or after normal school activities, such as attending before-school or after-school care on school operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent/guardian of the student shall sign a statement acknowledging that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by Iowa Code 280.16.

Name of medication/s	**Dosage**	**Time**	**Route**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Purpose of medication/s & Adminstration instructions?

_____

_____

Special Circumstances_____

Discontinue/Re-Evaluate/Follow-up date_____

Prescriber's Signature_____ Date_____

Prescriber's address_____

Emergency Phone_____

- I request the above named student possess and self-administer medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record and will report usage to parent/guardian. (Note: this bullet is recommended but not required.)
- I further agree that school personnel may contact prescriber as needed and that medication information may be shared with school personnel who need to know.

Student Signature (I agree to the above statements)	Date

Parent/Guardian Signature (I agree to the above statements)	Date

_____

Parent/Guardian Address

_____

Home Phone	Business Phone	Cell Phone

Additional information:

_____