

**MORRIS SCHOOL DISTRICT
HEALTH SERVICES
MEDICATION SELF-ADMINISTRATION FORM
(FOR PARENT, STUDENT, AND NURSE)**

This form must be completed and signed by the parent, the student, and the school nurse for self-administration of any medication for a potentially life-threatening illness, such as asthma or severe allergy. No other types of medications may be self-administered by students.

Student's name _____ Birth date _____ Grade _____

School _____ School year _____ Homeroom/teacher _____

The above-named student suffers from the following potentially life-threatening illness(es):

Asthma Severe allergy/anaphylaxis Other _____

The following medication(s), ordered by his/physician, must be readily available to him/her during the school day:

Metered dose inhaler – Medication name _____

EpiPen or other epinephrine pre-filled auto-injector mechanism

EpiPen Jr. or other epinephrine pre-filled auto-injector mechanism

Other – Medication name _____

I certify that the above-named student: 1) will carry his/her own pre-measured, properly labeled medication; 2) has been instructed in its safe and proper use; 3) is capable of self-administration, and; 4) feels comfortable and confident in self-administering it. I understand that he/she is obligated to notify the school nurse (or other school staff if the nurse is not available) as soon as possible after use. I further understand that this authorization is effective for one school year, provided that the student does not endanger him/herself or others through misuse. I agree to hold the Morris School District Board of Education and its employees harmless against any injury or claims that arise as a result of the self-administration of this medication by my child.

Parent/guardian's signature

Date

Student's signature

Date

I agree that the above-named student is capable of self-administration of the medication listed above.

School nurse's signature

Date