

Student Administered Medications

Student Name: _____ ***Shop*** _____
Medication: _____

I give authorization for self-administration and possession of emergency medication by my child while in school, at school sponsored activities, and while under supervision of school personnel. My child demonstrates a full understanding of the proper use of his/her medication and appropriate documentation has been submitted to the school.

I take sole responsibility for:

- ⊖ Monitoring the medication, medication use, and refilling of prescriptions for emergency medication(s).
- ⊖ Ensuring my child always carries his/her approved medication on his/her person.
- ⊖ Having backup medication available with the school nurse.
- ⊖ Informing school staff in writing of any changes in the treatment or management of my child's condition or medication.
- ⊖ Informing school staff in writing of any medication side effects that the school should notify me about if they occur.

I release the Schuylkill Technology Center and its employees and agents of any legal responsibility related to my child's possession and self-administration of his/her emergency medication(s).

Parent/Guardian's Signature

Date