

Springfield Public Schools
Self-Administration of Medication Record

School: **Glendale High School** Year **2021-2022**

Students may carry and self-administer a daily dose of over-the-counter or prescription medication if a parent's written request on the authorization below is on file in the nurse's office. The medication must be in the original container.

Prescription medication that is to be taken for 2 weeks or less may be carried and self-administered by the student if arrangements are made in advance with the nurse. Only a daily dose may be carried and the medication must be in the pharmacy labeled container and prescribed to the student. Prescription medication taken on a daily basis for longer than 2 weeks will be kept in the nurse's office.

Student Name _____ Birth Date _____ Grade _____

Medication _____ mg Dose _____ Times _____

For treatment of _____ Date to begin _____ Date to end _____

Physician Name _____ Physician Phone # _____

Pharmacy _____ Rx # _____ Expires _____

My child will be responsible for carrying and self-administering this medication. My child agrees to follow the school district's policy and procedure for carrying and self-administering medication. Failure to comply with the district's procedures will result in the loss of the privilege of carrying medication and may result in disciplinary action.

School personnel do not provide over-the-counter(OTC) medication for students at any time. All OTC medication must be provided by the parent or guardian.

Medication must be used in accordance with Springfield Public Schools Medication Policy according to School Board Policy JHCD.

Parent/guardian Signature _____ Date _____

Parents home phone _____ work _____ cell _____

The student must be able to state the name of the medication, correct dose, symptoms requiring medication, and correct timing of medication. Student agrees/understands they will not share medication with others and will keep medication in his/her personal belongings at all times.

Student Signature _____ Date _____

Student **does/does** not demonstrate meeting the requirements for carrying/self-administering this medication.

School Nurse Signature _____ Date _____