PARENT AUTHORIZATION AND STUDENT AGREEMENT
TO CARRY AND SELF-ADMINISTER MEDICATION OR HEALTH PROCEDURE

Student Name: ______________________________________ **Birth Date:** ___________________

Student's School/Program: _______________________/____

Medication/Health procedure: ____

Physician Name *: ________________________________ **Date of Authorization*:** ________ ___________
**Not applicable for asthma medication or epinephrine auto-injector*

<u>Student Agreement</u>

As the above named student, my signature below indicates that I understand and agree to the following:

1. I have demonstrated the proper administration of the above listed medication/health procedure to the School Nurse.
2. I agree to never share or ask another student to carry my medication or health procedure equipment in school and/or at school-related activities.
3. I agree that, if there are any problems or adverse side effects or after self-administering the medication or performing the health procedure, I will ask a teacher or other school staff member for assistance and/or to notify my parent/guardian or the School Nurse.
4. I agree to inform a teacher or other school staff member immediately if I lose my medication or health procedure equipment in school and/or at school-related activities.

Student's Signature: ______________________________________ Date: ________________

<u>Parent/Guardian Authorization</u>

By signing below, I give permission for my child or ward (named above) to receive the prescribed medication(s) and/or procedure(s) in school and/or at school-related activities. I agree that I am primarily responsible for administering medication to my child or ward. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize SWCCCASE and its employees and agents, on my behalf, to administer or to attempt to administer to my child or ward (or to allow my child or ward to self-administer pursuant to State law, while under the supervision of the employees and agents of SWCCCASE), lawfully prescribed medication or procedure in the manner described above. **I understand that:** 1) the medication or procedure will be administered by the SWCCCASE Program Nurse, a SWCCCASE Administrator, or other SWCCCASE staff member who volunteers to do so; 2) no medication (prescription or over the counter drugs) will be given to my child or ward until all required signatures are received by SWCCCASE; 3) the medication dosage will not be increased, decreased or discontinued without another proper prescription; and, 4) medication to be administered must be in its original container and appropriately labeled by the pharmacy. **I acknowledge that it may be necessary for the administration of medication to my child or ward to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless SWCCCASE and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration to or the self-administration of medication by my child or ward.**

Print Parent/Guardian Name: ___________________________________

Parent/Guardian Signature: ________________________________ Date: ______________