WEBSTER CENTRAL SCHOOL DISTRICT
PERMISSION FOR ADMINISTRATION OF MEDICATION/High School (Rev 05/23/11)
High School: _____Fax:_____
School Nurse: _____Phone:_____

If your child needs medication during school hours, either prescription or over the-counter, you must comply with the following or medication cannot be administered: **Daily Medication Orders may NOT be used for Overnight or After-hour Field Trips**

1. Have your child's physician complete the **Physician Statement** section of this form entirely;
2. Complete the **Parent Statement** section of this form entirely;
3. Parent must bring the medication to school in the original container. **A second identically labeled container is required for daily medications required for school day field trips**. Your child may **NOT** bring the medication to school (unless authorized to self-carry & self-administer).

Student's Name: _____**DOB**: _____

PHYSICIAN STATEMENT **SCHOOL YEAR: _____**

Medication:			
Dosage:			
Time:			
Duration:			
Possible side effects:			
Reason for medicine:			

If the morning dose usually given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.
Drug: _____AM Dose: _____

Based on the definitions below, I assess this student to be: ___X__**May use for School Hours Field Trips**
__X__self-directed; _____not self-directed;
__X__able _____unable to carry and self-administer medication. (School nurse to assess the student's abilities in a school setting) **Controlled medication may not be carried by student**.
__X__The prescribed EMERGENCY MEDICATION (ie. Inhalers, Epi-pen, Glucagon) may be self-carried during all Field Trips & Sports Participation

_____ _____
Physician's signature Office Stamp Date

PARENT STATEMENT

By completing and signing this form, I give permission for my child as named above, to take this medication as prescribed above; I also give my permission to the nurse/health office staff to discuss problems/concerns with this medication with the prescribing physician. **I understand the determination of whether my child is self-directed or not self-directed is the ultimate responsibility of the school nurse/physician overseeing the medication in a school setting**. I further understand that any assessment may change based on a student's demonstration of responsibility. To help in that assessment, I assess my child to be:

_____**Not Self -directed** (must be reminded & supervised in storage & administration of medication).
__X__**Self-directed** (can recognize medication, knows dose and time of delivery, and can refuse to take the wrong medication from an authority figure).
_X___**Able to carry and self-administer** (as in self-directed, plus understands need to keep medicine away from other students and safely stored, can recognize when medication supply needs replenishing, can keep track of dosing and timing of medication, know to seek assistance from health office if medication is not working). **STUDENTS MAY NOT CARRY CONTROLLED MEDICATION.**

_____ _____ _____
Parent signature Daytime phone # Date