School Authorization Medication Form 2023-2024
(One form per child if applicable)

All medication, whether prescribed or over-the-counter must be kept in the Main Office. No medication is permitted to be carried on the student with the exception of rescue medications such as EpiPens, inhalers and insulin supplies. If your child requires to carry / self-administer a rescue medication please fill out the ***Authorization to Self-administer Medication*** form. This form is valid for one year.

Part 1: Over-the-Counter Medication: Students that require medication during the school hours, whether prescription or over the counter, may only self-administer or have such medication administered in accordance with School policies and applicable state law. In order to administer medication during the school day, St. John Fisher School must have this signed document on file. Non-prescription medication brought to the school office must be in the original package with the *student's name, date of birth, and grade affixed to the container.* This applies to medication for headaches and cramps, or any other medical condition.

**Office staff will call parents before giving any medications.

Student Name:_____DOB:_____Grade:_____

OTC Medication Name:_____Dose:_____Frequency_____

Parent/Guardian Signature:_____Date:_____

Part 2: Prescription Medications: If your child requires to take prescription medications throughout the school day you must fill part 2 below. Medications must be brought to the Main Office in its original container, including the *student's name, date of birth and date of expiration.*

Student Name: _____DOB_____Grade:_____

Medication:_____Date of Expiration:_____

Form of Medication: ___Tablet/Capsule ___Inhaler ___Injection ___Nasal

Dose:_____Time & Frequency:_____

Conditions When to be Given:_____

Parent/Guardian Signature:_____Date:_____

Primary Care Provider Signature:_____ Date:_____

ST. JOHN FISHER SCHOOL

Authorization to Self-Administer Medication

Part 1: Parent Authorization:

State Law requires that we inform the parents/guardian of the student, in writing, that the school and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of rescue medications including, but not limited to, asthma, allergy and diabetes medications. A student with asthma, allergies and or other medical conditions may possess and use his/her medication while in school, at school-sponsored activities, while under the supervision of school personnel, or before or after regular school activities. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses the medication. Please note the following:

- **School Authorization Medication Form** is required to be completed along with this form.
- This form is valid for one school year and must be resubmitted each year.

I, _____ Parent / Guardian of _____
acknowledge that St. John Fisher and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of rescue medications including, asthma, allergy and diabetes medications by the student. I indemnify and hold harmless St. John Fisher and its employees and agents against any claims arising out of self-administration of medication by the student. I give permission for my student to carry and self-administer the medication below, as ordered by his/her health care provider. I certify that my child has been instructed in the use and self-administration of this medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I will notify the school of changes in medication or my child's condition.

Parent / Guardian Signature: _____ Date:_____

Part 2: Health Care Provider Authorization

Student Name:_____ DOB:_____ Grade:_____

Student Condition: Asthma Allergy Diabetes Other_____

Medication:_____ Dose:_____ Frequency:_____

Possible Side Effects:_____

I certify the above named student has been instructed in the use and administration of this medication. He/she understands the need for medication, and the necessity to report any unusual side effects. He/she is capable of using this medication independently.

Primary Care Provider Signature:_____ Date:_____