Holy Family
Catholic High School

School Year: _____

Self-Administration Authorization of Non-Prescription Pain Relievers

To Be Completed By Parent/Guardian

I request and authorize my child _____ to carry and/or self-administer their medication _____.

This authorization is given and based on the following:
I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication. I understand that if my child misuses by not taking the manufacture's recommended dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-administer non-prescription pain reliever medication at school.

Parent/Guardian Signature:_____ Date: _____

Student Agreement

Medication is permitted in accordance with district policy and procedure(s).
I, _____, agree to the responsibilities of carrying medication.
___ The student can demonstrate correct use/administration.
___ The student can recognize correct dosage.
___ The student recognizes proper and prescribed timing for medication.
___ The student agrees to not share the medication with others.
___ The student will keep the medication in an agreed upon location.
(Please indicate location: _____)
___ The student will keep a second labeled container in the health office. (optional)
___ The student will notify the Health Service Office under the following circumstances:
- Symptoms continue or get worse after taking my medication
- Suspect that I am experiencing side effects from the medication
- Other: _____

Student Signature:_____Date: _____
Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Building Principal and District Nurse.

To Be Completed By Registered Nurse/Licensed School Nurse

The student is / is not able to demonstrate the specified responsibilities.

The student may carry the medication unless and until he/she fails to follow the above agreement.

RN/LSN Signature:_____Date: _____