FORM 2 (page 1) AUTHORIZATIONS FOR SELF-MEDICATION BY DPS STUDENTS

This form should be used only when your child will possess and self-administer his/her medication.
If school personnel will be administering medication to your child, please request Form 1.

Child's Name: **DOB:**

School Name: **Phone:**   **Fax:**

Eligibility: In accordance with DPS Policy 4400, Student Health/Administration of Medication, students may possess and self-administer non-prescription medication only when a parent/guardian has completed this form. Students may possess and self-administer prescription medications that are not controlled substances only when a parent/guardian and the physician who has prescribed the prescription medication complete this form.

Parent/Guardian: I give consent to the Durham Public Schools to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I agree that if the medication my child is authorized to self administer is non-prescription, my child shall not bring to school any more than one day's recommended dosage for each day my child is authorized to self-medicate. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, I agree to provide a supplementary supply of the medication that will be kept by the school in a location to which my child has immediate access. I acknowledge that the Durham Public Schools' Board of Education and their agents and employees are not liable for any injury arising from a student's possession and self-administration of this medication at school. I agree that if my child uses his/her medication in a manner other than as intended or prescribed, or shares the medication with other students, my child may be subject to disciplinary action according to the discipline policy. I further consent for the information about my child included on this form to be shared with appropriate school staff as necessary for the safety of my child.	
Parent/Guardian Signature	Date
Please complete if you are authorizing your child to possess and self-administer non-prescription medication.	
Medication:	Recommended dosage and frequency:
Start date:	End date:

FOR PHYSICIAN USE ONLY: ***PLEASE WRITE LEGIBLY USING LAY TERMS***	
Health Care Provider: The student named above has (1) asthma or an allergy that could result in an anaphylactic reaction and may require emergence medications; or (2) a condition that requires frequent administration of a prescription or non-prescription medication. The medication is not a controlled substance. It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. This student is capable of, has been instructed on the procedures for, and has demonstrated the skill to self-administer this medication as directed below. Please allow him/her to self-administer the medication while on school property during the school day, at school sponsored activities, while in transit to or from school or school-sponsored events, or as otherwise indicated below. This student **will not** require adult supervision while taking this medication.	
Medication prescribed:	Strength/Dose:
Purpose of Medication:	
Frequency of dosage:	
Specify side effects or adverse reactions:	
Other instructions (including emergency situations):	
☐ Please check if this medication is to be used for emergencies only.	
Signature of health care provider	Date
Please print provider's last name	**Practice name/address**

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Student: I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school-sponsored activities. Unless the medication is prescribed for the treatment of asthma or anaphylactic reactions, I understand that I will lose the privilege of self-administering my medication if I do not follow these rules.

Student signature	Date

School Nurse: I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he or she must tell and appropriate staff member whenever he or she has used the medication at school.

Nurse or designee signature	Date