OTSELIC VALLEY CENTRAL SCHOOL

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Richard J. Hughes, Superintendent of Schools, rhughes@ovcs.org
George Lott, School Business Manager/Treasurer
Gail Evans Burpee, District Clerk

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

AT SCHOOL AND AFTER –SCHOOL ACTIVITIES

A. To be completed by the licensed health care provider:

(Students name)_____has been instructed in the proper use of the following medication(s):

_____

In my professional opinion, this student should be allowed to carry and use the above medication(s) by him/herself

_____ _____

(Licensed prescriber's signature) (Date)

B. To be completed by parent or guardian:

I request that my child, _____, be permitted to carry the above prescribed medication(s) on his/her person or kept in his/her locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. The student understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

_____ _____

(Parent/Guardian signature) (Date)

The licensed prescriber's statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

_____ _____

(School Nurse's signature) (Date)

NOTE: This form must be completed <u>in addition</u> to the parent and prescriber's authorization form for administration of medication in school.

Date form received in health office _____