AUTHORIZATION FOR SELF-MEDICATION BY CMS STUDENTS

Student's Name____ Birthdate______________________

Medication__________________________________for ____________________________________

Eligibility: In accordance with CMS Policy JLCD, Administering Medications to Students, and its accompanying regulation, JLCD-R, only students who meet the following descriptions may possess and self-administer medications: (1) Students with special medical needs such as asthma and/or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e., asthma inhaler or epinephrine auto-injector ["Epi-pen]); and (2) Students who require frequent administrations of non-prescription medications or prescription medications that are not controlled substances.

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Healthcare Provider: The student named above has (1) asthma or an allergy that could result in an anaphylactic reaction and may require emergency medications; or (2) a condition that requires frequent administration of a prescription or non-prescription medication. The medication is not a controlled substance. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication as directed on page 1 of this form. Please allow him/her to self-administer the medication during school hours and as otherwise indicated on page 1 of this form.

This student will not require adult supervision while taking this medication.

Physician signature/date____

Parent/Guardian: I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. 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 absolve the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medication at school. I further consent for the information about my child included on pages 1 and 2 of this form to be shared with appropriate school staff as necessary for the safety of my child.

Parent signature/date ____

Student: I am capable of taking this medication 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 an appropriate staff member whenever he or she has used the medication at school.

Nurse signature/date ____