Oconee County School Health Services

Self-Administration of Medication/Medical Procedures

Student's Name_____

Date of Birth_____ **Telephone**_____ **Drug Allergies**_____

Name of Medication/Medical Procedure_____

Starting Date of Medication/Medical Procedure_____

Time Medication/Medical procedure is to be provided daily_____

Termination date for administering the Medication/Medical procedure_____

Physician's requirements of dosage/method of administration

_____

Precautions, possible side effects, interventions_____

This student is recommended to possess and self-administer this medication/medical procedure as ordered.

Physician's Signature_____ **Physician's Phone**_____

_____

Date

I understand that the Oconee County School System and its employees are not liable for adverse effects or injury due to the above mentioned student self-administering (or not administering) this medication.

The student is capable of self-administration and understands that any misuse of a prescription drug is a felony.

The nurse has permission to dialogue with school personnel regarding this medication and any related issue.

In the event that the school has questions regarding the medication or a problem associated with the medication, I hereby give permission for school health officials to dialogue with our physician.

_____ _____

Date **Signature of Parent/Guardian**