

SAINT AGNES SCHOOL



913-262-1686 • 5130 Mission Rd. • Roeland Park, Kansas 66205

Self-Administered Medication Release

PART A: Parent/Legal Guardian to Complete – for students K-12

Name of Student: _____ Date of Birth: _____ Grade: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning:

1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube);
2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule);
3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom);
4. other pertinent issues related to the student's diagnosis, condition, or treatment.

 Parent/Legal Guardian Signature Parent/Legal Guardian (Printed Name) Today's Date

PART B: Physician to Complete

Medication	Purpose	Dosage	Time / Frequency

Conditions & Special Circumstances for use: _____

Length of time medication is to be administered: _____

 Physician Signature Printed Name Phone Number Today's Date

PART C: School Nurse to Complete

School Nurse Review of order and procedure with the student. Completed _____
Date of Review

RETURN TO SCHOOL NURSE