Form ACBD-E3

DICKINSON PUBLIC SCHOOLS
SELF ADMINISTERING MEDICATION CONSENT FORM
(PHYSICIAN'S SIGNATURE REQUIRED)

FOR ANY MEDICATION THAT WILL BE SELF-ADMINISTERED INCLUDING: **Asthma, Anaphylaxis and Prescription medication or Over-the-counter medication if it is to be provided in a manner inconsistent with manufacturer's recommendation.**

Name of Student _____ D.O.B._____
Address_____ School_____
Parent/Guardian's Name _____
Phone- Home _____ Cell _____ Work_____
Emergency Contact (other than parent) _____
Phone- Home _____ Cell _____ Work_____
Health Care Provider Name _____Phone_____
Pharmacy_____ Phone_____

Health Care Provider Section

Diagnosis _____
Name of medication/treatment_____
Dose_____
Time(s) to be administered at school _____
Method (route) of administration:
◯Mouth ◯Eyes ◯Ears ◯Nose ◯Topical (eg. Skin ointment) ◯ Inhaler ◯ Epi-Pen
◯ Other _____ (Please contact school administrator)
Medication to be administered from _____to_____(Month/Day/Year)
Precautions and reactions to observe and report to parent/physician:_____
_____
Student Allergies _____
Comments _____

☐ **I CERTIFY THAT THE ABOVE NAMED STUDENT IS CAPABLE OF SELF-ADMINISTRATION OF THE ABOVE PRESCRIBED MEDICATION.**
☐ **I CERTIFY THAT THE ABOVE NAMED STUDENT MAY CARRY THE ABOVE MEDICATION.**

_____ _____ _____
Healthcare Provider's Name (please print) Health Care Provider Signature Date

PARENTAL CONSENT

I authorize my child to self-administer the above medication while at school and relieve the school district and personnel of all responsibility. The student may carry one days supply of medication, unless supplied in a multi-dose container (ie. Inhaler, epi-pen, etc.) I acknowledge that I have read, understand, and agree to comply with the School District's medication program policy. I certify that medications I have authorized the school to provide to my child do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I certify that the information included on this form is accurate to the best of my knowledge. I understand and hereby release Dickinson Public School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____
Name of Parent/Guardian (please print) **Signature of Parent/Guardian** **Date**
******One medication per form**

(OVER)

*****A new form is required each time the student has a new medication or if there is a change in the student's current medication.**

DICKINSON PUBLIC SCHOOLS

Student Consent (Grade 6-12)

I acknowledge that I have read, understand and agree to comply with the School District's medication program policy. I also acknowledge and agree to comply with the District's drug and alcohol free schools policy, which contains restrictions related to medication, including rules prohibiting me from giving medication to other students.

Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another school employee.

I agree that I will not leave the medication unattended, unsecured or accessible to other students.

_____ _____

Student's Signature **Date**

CONFIDENTIALITY WAIVER

NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA/FERPA).

I _____ (parent/guardian's name) authorize (name of agency and/or health care providers):_____
to provide health information from _____(student's name) medical record to:
_____(name of school).
The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.
Requested information shall be limited to the following: ☐All minimum necessary health information; or
☐ Disease/condition-specific information as described:
_____
This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for the remainder of the school year.
Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.
I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.
I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____

Parent/guardian's signature Date

NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider upon completion

End of Dickinson Public School District Exhibit ACBD-E3