WARWICK SCHOOL DISTRICT
MEDICATION SELF ADMINISTRATION
(For School Sponsored Activities Outside of the School Day)
AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME_____ BIRTHDATE_____

Advisor/Coach/Teacher: _____

Activity: _____

Date(s) of Activity: _____ Time of Day: _____

By signing below:

1. I authorize the Warwick School District and its employees to allow my child to possess and self-administer his/her medication (listed below) during the school sponsored activity listed above.
2. I understand that, while in school, the medication may not be carried by my child and must be kept in the nurse's office until the end of the school day. It is my child's responsibility to pick up the medication from the nurse's office prior to the activity.
3. I understand that I will provide **only one dose** of the medication in the original medication/pharmacy container **each day** my child is to be involved in the before/after school activity.
4. I acknowledge that the school bears no responsibility for ensuring that the medication is taken or properly self-administered.
5. I agree that the school nurse may contact my child's health care provider for the release and exchange of information concerning my child's diagnosis and treatment.
6. I understand that neither the district nor any of its employees shall be held liable for any injury resulting from self-administration of the medication, and I agree to indemnify and hold harmless the school district and its agents against any related claims.
7. I agree that if my child abuses or misuses this privilege, school personnel may confiscate the medication and the district will remove my child's privilege to carry the medication.

_____ _____
Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Medication _____ Dosage_____

Time and frequency to be administered _____

Diagnosis_____

Possible Side Effects_____

As the health care provider for this student, I verify that he/she has been taught to properly administer his/her medication, has adequate knowledge of his/her medical condition, and is thought to be responsible enough to carry his/her medication and administer it properly without supervision.

_____
Physician's Printed Name Address Phone

_____
Physician's Signature Date Fax Number

NOTE: EACH MEDICATION REQUIRES A SEPARATE FORM. REQUESTS ARE EFFECTIVE ONLY FOR THE ACTIVITY LISTED ABOVE AND MUST BE RENEWED FOR ANY SUBSEQUENT ACTIVITY.
(Rev. 4/12)