Authorization For Student to Self-Carry and Independently Self-Administer Medication(s)/Procedure(s) for Headache

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by parent:

I request for my child to carry and self-administer medication for headache during the school day, at school-sponsored activities or while in transit to or from school. My child has demonstrated the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, for their health condition. Supervision will not be provided by the school. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the school harmless against any injury or claims that arise as a result of the student's self-management for headache. School personnel will contact you if there are questions or concerns about the child's healthcare condition and medication. The school reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication with me at school.
☐ I will use only as prescribed by my healthcare provider.
☐ I will not allow any other person to use my medication(s)
☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*

(Updated July 2023)