UNIVERSITY SCHOOL
EAST TENNESSEE STATE UNIVERSITY

68 Martha Culp Drive, ETSU, Johnson City, TN 37614
Phone:(423) 439-4333 Fax:(423) 439-5921

AUTHORIZATION TO ASSIST COMPETENT STUDENT WITH SELF-ADMINISTRATION OF MEDICATION

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to bring this medication to school and remove any unused medication when treatment is completed.

All prescription medication must be brought to school in the original container. The pharmacy label must include the following information:

Name of student
Prescription Number
Name of medication and dosage
Administration route or other directions
Date
Licensed prescriber's name
Pharmacy name, address and phone number

All non-prescription medication must be brought to school in the original manufacturer's labeled container with the ingredients listed and the child's name affixed to the container. **Herbal/homeopathic medication shall be administered only with a physician's order and a completed medication form signed by the parent.**

No more than one month's supply of any medication should be brought to school.

PARENT/GUARDIAN AUTHORIZATION

Student's Name: ____________ **DOB:** ________ **School:** ____________ **Date:** ________

I request that school personnel assist the above named student to self-administer the following medication while in school and away from school for school activities.

Name of Medication:___________________________________ Amount of Medication to be taken:______________________

How medication is to be taken (orally, topically, inhalation, injection):____

Time(s) medication is to be taken:___________________Date the last dose of this medication is to be taken:______________

Reason medication is needed at school:____

Possible Side Effects of medication:____

Date:___/___/___ Physician Name: ____________________ Physician Phone: _________________________
Physician Signature: ____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by Washington County School System, the undersigned parent/guardian hereby agrees to release the Washington County School System and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. **I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.**

Parent/GuardianSignature______________________________Date:________________________
Parent/Guardian Name___________________________Home Phone #________________Work Phone #_________________
Comments:____