

## Cabell County Schools Health Services

## Authorization for Self-Administration of Emergency Medication and/or Over the Counter Medication

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ HR Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Emergency Medications:** Students prescribed emergency medications are permitted to self-administer per parental permission and by successfully completing the medication administration evaluation by their school nurse. The Medication Administration/Medication Log Form must be completed for emergency medication (Epi-Pen, Inhaler, etc) only. The medication must be in the manufacturer's original packaging clearly marked with name of the medication, ingredients, dosage, time, route, and medication expiration date.

**Over the Counter Medications:** ONLY students in grades 9-12 are permitted to self-administer Over the Counter Medications. The medication, up to a 3-day supply, must be in the manufacturer's original packaging clearly marked with name of medication, ingredients, dosage, time, route, and medication expiration date.

**The student must maintain possession of any medication that they are given permission to carry by the school nurse and the parent while at school. I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I am aware and understand that the school, Cabell County Board of Education (CCBOE), and its employees or agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student. I hold harmless the school, CCBOE, and its employees or guardians, and agents against any claims arising out of the self-administration of medication by the student. I also understand that if my child fails to follow the said agreement, privileges to self-medicate will be withdrawn and/or may be subjected to disciplinary action.**

\_\_\_\_\_  
Parent/Guardian Printed Name & Signature\_\_\_\_\_  
Phone Number\_\_\_\_\_  
Date

### For School Use Only

### Assessment of Student Responsibilities for Carrying and Administering Medications School Nurse Observed:

Yes	No	Assessments:
<input type="checkbox"/>	<input type="checkbox"/>	Medication expiration date:
<input type="checkbox"/>	<input type="checkbox"/>	Medication prescribed by physician (ER med only).
<input type="checkbox"/>	<input type="checkbox"/>	Medication in original container and labeled with student name.
<input type="checkbox"/>	<input type="checkbox"/>	Student demonstrates correct use/administration.
<input type="checkbox"/>	<input type="checkbox"/>	Student recognizes proper and prescribed timing for medication.
<input type="checkbox"/>	<input type="checkbox"/>	Student states understanding of not sharing medication with others.
<input type="checkbox"/>	<input type="checkbox"/>	Student agrees to notify teacher/staff should symptoms persist.
<input type="checkbox"/>	<input type="checkbox"/>	Student agrees to keep medication in an agreed upon location for emergency use: purse, backpack, locker, _____.

**The student has passed an assessment by the school nurse evaluating the student's technique of self-administration and the student's level of understanding of the appropriate use of emergency and/or OTC medications.**

Student's Name (Print &amp; Signature): \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse (Print &amp; Signature): \_\_\_\_\_ Date: \_\_\_\_\_