Crow Creek Tribal Schools
Nursing Department
605-852-2258 Ext. 270 Sammi Ext: 450 Tiffany FAX: 605-852-2669

Authorization for Self-Administered Medication

Medical Authorization (Use this form for EpiPens and Inhalers)

Name of Student _____Birth date _____

Medical Diagnosis _____

Name of Medication_____

Purpose of Medication _____

Dosage_____Route_____Frequency_____

Time or circumstance the student is to take medication:

_____

I authorize that this student is capable of self-administering this medication.

Authorization start date: _____ Authorization end date:_____

_____
Signature of Physician/Licensed Health Care Provide

_____

Parental Authorization

I authorize my child to carry and self-administer the above prescribed medication while on school property or at a school-related event or activity. I understand that medication must be provided in the original container stating the name of the medication, student's name, the name of the pharmacy, physician's name and the dose to be given. If my child uses the medication in a manner other than prescribed, my child may be subject to disciplinary action by the school. However, the disciplinary action may not limit or restrict the immediate access to the medication.

Parent/guardian signature _____Date _____

Parental Release of Liability

I absolve the Crow Creek Tribal School and its employees and agents from liability for an injury arising from the student's self –administration of this prescription medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

Parent/guardian signature _____ Date_____