Request to Self Carry and Self Administer Over the Counter Medications

Student Name: ______________________________ Drug Allergies:____________________

I request and authorize my child to carry and/or self-administer this over the counter medication

_____________________________ (name of medication).

This request is based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry this medication as long as the medication is only for self-use, is not shared with others, and is used in accordance with the manufacturer's recommendations.
- My child has taken this medication at home and has had no side effects or reactions to it.
- No aspirin containing medications may be taken at school without a physician's order.
- I understand that if my child misuses or endangers others with the medication, the medication will be confiscated and may be referred for disciplinary action.
- I understand that this request is effective for the current school year and must be renewed annually.

Parent Name (Please Print)____

____ Date: __________________
Parent/Guardian Signature

Student Agreement

I, _______________________________, agree to:

- Follow the manufacturer's guidelines regarding the use and dosage of this medication.
- Use correct medication administration technique.
- Not allow anyone else to use my medication.
- Notify the Health Office under the following circumstances:
  - My symptoms continue or get worse after taking my medication
  - I suspect that I am experiencing side effects from my medication
  - Other____

____ Date: __________________
Student Signature

Buffalo High School Acknowledgement and Notification that ____________________________
Will be self-carrying and self-administering his/her medications.

Reviewed and accepted by: ______________________________________ Date: ____________
Licensed School Nurse

Reviewed 3/19