Quincy Public Schools

Permission to Self-Transport/Administer Medication Agreement

Student Name: _______________________________ DOB: ________________ Grade: ______

With parent permission, a statement of the student's ability to self-transport/administer his/her medication from the prescribing medical provider, and a school nurse's evaluation, students in QPS may self-transport/administer certain emergency medications. The medication must be transported in the original container, and the student should only carry a daily dose of the medication. The student is responsible to maintain his/her medication in an appropriate and accessible place at all times. The transport/use of undisclosed medications may result in disciplinary action according to the student code of conduct.

I, ____ [parent/guardian name], give permission to my son/daughter to transport and self-administer the medication(s) listed below while on a school campus. My child has demonstrated his/her understanding of proper medication use and understands that the medications listed below are not to be shared with others or taken in any way other than directed by the prescribing physician or manufacturer. I also understand that the misuse of medications can result in disciplinary action for my child according to the student code of conduct. On this form, I have disclosed all medications that my child is permitted to carry.

Parent Signature: ____ Date: ____/____/20___

I, ____ [student name], understand proper medication use and that the medication(s) listed below is only for my use during the school day. I will be responsible with my medication(s), take it only as directed by the prescribing physician or manufacturer, store them in a safe place in my belongings, and I will not share them with others under any circumstance. I also understand that the misuse or sharing of my medications can result in disciplinary action according to the student code of conduct. I will seek assistance from the school nurse or a responsible adult if I must administer an emergency medication(s) while at any QPS school.

Student Signature: ____ Date: ____/____/20___

Medication 1: ____________________________ Dose: _________________________ Route: ________________
Reason for use: ____ Expiration date: ____/____/20____

Medication 2: ____________________________ Dose: _________________________ Route: _________________
Reason for use: ____ Expiration date: ____/____/20____

For school nurse use only

I certify that the student named above:

Knows the name and purpose of the medication(s) he/she will self-transport	Yes / No
Knows the prescribed medication dose	Yes / No
Articulates the appropriate time and circumstance under which the medication(s) should be administered	Yes / No
Demonstrates the correct administration of the medication(s) listed above	Yes / No
Understands the period for which the medication(s) is/are prescribed	Yes / No

School Nurse Signature: ____ Date: _____/_____/20_____