Bethlehem Area School District
Self Administration of Medication by Students

_____ _____ _____
Student's Name Grade Date

To self medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____
Name of Medication Dosage Frequency

The above named student has demonstrated the ability to self-administer the prescribed medication as indicated by the criteria listed above.

_____ _____
Date Signature (Certified School Nurse)

As the parent/guardian of the above named student, I relieve the school district and it employees of any responsibility fir the benefits or consequences of the above listed medication when it is prescribed and parent authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper sharing of the above named medication will result in the immediate confiscation of the medication and loss of privilege to self-administer if the medication policy is violated.

_____ _____
Date Parent/Guardian Signature

I agree to be solely responsible for my medication and to follow the direction for its use as ordered by my health care provider, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my medication.

_____ _____
Date Student's Signature

Rev. 10/12