# *DORCHESTER SCHOOL DISTRICT TWO*
## *Division of Nursing Services*

**PARENTAL AUTHORIZATION FOR STUDENT SELF-MONITORING AND/OR SELF-ADMINSITRATION OF A PRESCRIBED MEDICATION FOR A MEDICAL CONDITION.**

I hereby authorize my child, _____, to self-monitor and/or self-administer a prescribed medication as ordered by his/her health care practitioner as described in the attached Health Care Practitioner Authorization, while at school, on school grounds, at school-sponsored activities, or during before or after-school activities on school-operated property.

I understand that this authorization must be updated annually, including an updated health care practitioner's authorization. I also understand that my child's permission to self-monitor and/or self-administer a prescribed medication for a medical condition shall be revoked if he/she demonstrates lack of responsibility or endangers him/herself or others through misuse of the monitoring device or medication.

I hereby acknowledge that Dorchester School District Two, its employees and agents, are not liable for any injury arising from my child's self-monitoring or self-administration of a prescribed medication. Further, I hereby agree to indemnify and hold harmless the former against any claims arising from my child's self-monitoring and/or self-administration of a prescribed medication. I also authorize that my child's health care plan be shared with the school staff who have a legitimate need for knowledge or the information.

Child's Name: _____
Last First Middle

Gender: Male/Female Date of Birth: _____ Grade/Section: _____

_____
Street Address

_____
City, State, Zip

Parent Numbers
Home Phone: _____
Cell Phone: _____
Pager: _____
Work Phone: _____

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Student Date

_____ _____
Signature of School Nurse Date

_____ _____
Signature of Principal Date

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