

Student Information Form

information

- ❑ All medication must be in original container or packaging with your child's name on it.
- ❑ Your child may not self-administer controlled substances such as psuedoephedrine.
- ❑ If it is locked up at the pharmacy, it has to come from a certified staff member.

Self-Administration Waiver



AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AND WAIVER AND INDEMNIFICATION FROM LIABILITY

The undersigned parents/guardians ("Parents") hereby authorize the Rockwood School District ("District") to allow the Parents' child named below ("Child") to self-administer the medication(s) stated below ("Medication"), and represent to the District that the history stated below of the child's experience with the illness being treated by the Medication is accurate and complete. The Parents also authorize the District to implement the plan of action stated below for addressing any emergency situation which may arise as a consequence of the Child self-administering the Medication.

The District hereby notifies the Parents that neither the District, its employees nor its agents shall incur any liability as a result of any injury arising from the self-administration of the Medication by the Child, and the Parents hereby acknowledge that no such liability shall exist, and on behalf of themselves and the Child hereby waive any such liability. Furthermore, the Parents hereby agree to indemnify and hold the District, its employees and its agents harmless against any claims whatsoever arising out of the self-administration of the Medication by the Child.

Name of Child: _____

Medication(s): _____

Medical History: _____

Emergency Plan of Action: _____

For School Year: _____ (MUST BE RENEWED ANNUALLY)

Signatures:

Parent/Guardian _____ Physician Signature _____

Date _____ Date _____

PHYSICIAN'S CERTIFICATION MUST BE ATTACHED.
FAX NUMBER FOR LHS SCHOOL NURSE: 636-458-7232

Self-Administer Waiver

- ❑ THIS IS A VERY IMPORTANT DOCUMENT!
- ❑ YOU MUST FILL THIS FORM OUT COMPLETELY AND ACCURATELY!
- ❑ THIS FORM MUST MATCH THE INFORMATION FORM!!!!!!!

Self-Administration Waiver

Name of Child: _____

Medication(s): **LIST ALL MEDICATIONS! - prescription and OTC** _____

Medical History: _____

Emergency Plan of Action: _____

For School Year: **2008-2009*** (MUST BE RENEWED ANNUALLY)

*This document is good for the entire school year!



Self-Administration Waiver

- Your child may not self-administer controlled substances.
- If it is locked up at the pharmacy, it has to come from a certified staff member.
- All medications must be in their original containers with your child's name on them.

Self-Administration Waiver

Signatures:

Parent/Guardian

Physician Signature

Date

Date

PHYSICIAN'S CERTIFICATION MUST BE ATTACHED.
FAX NUMBER FOR LHS SCHOOL NURSE : 636-458-7232

**THIS FORM IS GOOD FOR THE ENTIRE SCHOOL
YEAR IF NO MEDICINES CHANGE.**

Turn-In Dates

- Thursday, July 10 2-4pm
- Monday, July 14 5-6pm
- Mail to:

Brad Balog
c/o Lafayette High School
17050 Clayton Road
Wildwood, MO 63011

**ALL TRIP FORMS MUST BE IN OUR
HANDS BY JULY 14TH**