Platte County
HOME OF THE PIRATES
Tradition. Pride. Vision.

Permission to Self-Carry Medications

I, _____, the parent/guardian of _____, a student in the Platte County R-III School District, give my permission for the student to retain in his/her possession the following medications:

_____.

This permission shall be effective for the 20___ - 20___ school year and must be renewed annually. This medication will be carried to and from school by the student and maintained in the student's backpack or special carrying device during school hours.

I have provided the District with the following:

- A written medical history of the Student's condition for which the medication is required on the Health Information Form or other documentation.
- An Action Plan for addressing an emergency situation that could reasonably occur as a result the condition.

I understand that the District and its employees or agents may disclose information provided to administrators, school nurses, teachers and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-carry the medication and shall incur no liability for the disclosure of such information.

I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medications by the Student, absent any negligence by the District, its employees or its agents. I shall indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administrations of medication by the Student.

_____ _____

Signature of Parent/Guardian Date

_____

I certify that I am a licensed physician authorized by law to prescribe medication. I have prescribed the following medication, _____ for my patient, _____ to treat or manage the following condition, _____.

I further certify that I have instructed the student in the correct and responsible use of this medication, attached a treatment plan for managing the student's condition and that the student is capable of self-administering the medication in accordance with the treatment plan. The student has demonstrated to me or my designee the skill level necessary to self-administer the medication.

_____ _____ _____

Printed Name of Physician Signature of Physician Date