DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS
WIESBADEN HIGH SCHOOL
Unit 29647
APO AE 09096

Office of the School Nurse

Permission for Student to Retain Control of Medication

(make sure all 3 sections are fill out and signed)

Section 1: To be completed by physician:

Name of Student _____Age _____ Grade _____
Diagnosis:_____ Duration of treatment: _____
Times of day/circumstances under which medication is to be given:

_____

Reason student must have possession of medication at all times:

_____

Expected results from using the medication:

_____

Expected time frame to achieve results following medication administration:

_____

What student should do if the expected results are not obtained in the specified time frame:

_____

I have instructed the student and the student's parent in the proper use and method of administering this medication and the legal consequences of using the medication inconsistently with the prescription or of sharing the medication with anyone else. I have provided the student and his/her parents with the following instructions regarding the symptoms of possible adverse reactions, contraindications, and what to do if student experiences difficulty with or while taking the medication:

_____

_____

The student's medical condition is such that the student must be in possession and control of the medication at all times and be free to administer the medication when needed. **In my opinion, the student possesses sufficient maturity and responsibility to follow my instructions**.

Physician's signature: _____

Date: _____Phone#: _____

Section 2: To be completed by Parent:

Name of Parent(s)_____

Home: _____ Work: _____ Cell: _____

I have read the physician's statement and hereby consent to my child retaining possession at all time of the above prescribed medication. I understand, and have informed my child, that any illegal use of the medication by the student (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action.

During school hours my child has been instructed to take their medication in the nurse's office. I will provide extra medication to be kept in the school nurse's office as backup for the one carried by my child.

Parent's signature: _____Date: _____

Section 3: To be completed by Student:

I understand that I am required to retain possession and control of my prescribed medication in accordance with the terms set forth in Section 1 above,

I have been advised of my responsibility to use my medication only in strict accordance with the prescription.

I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use as is the sharing of my medication with another person. I agree to carry a pharmacy labeled container of the medication, to keep a record of the times I use my medication and to share the information with the nurse/instructor/coach who will help evaluate and monitor the effects of my medication.

During school hours I will take my medication under the supervision of the school nurse.

Students signature: _____ Date: _____