

# **HONEOYE FALLS-LIMA**

## **Central School District**

**Community Programs & Aquatics Department**

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### **Honeoye Falls – Lima *Cougar Care* Before and After School Care Program Request for Student Self-Medication**

Student Name: \_\_\_\_\_

School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

The child listed above has been instructed in the proper use of the following medication and procedures:

Name of Medication(s): \_\_\_\_\_

Medication(s)Procedures: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian and Health Care Provider request that the child be permitted to carry on his/her person and to self-administer (check below):

\_\_\_\_\_ A one-day supply of medication

\_\_\_\_\_ A prescribed inhaler

He/she understands the purpose of the medication, and the appropriate method of administration and the prescribed frequency of use. He/she will assume responsibility for complying with all proper procedures. These procedures must be followed or the privilege will be rescinded.

Parent/Guardian

Health Care Provider

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## Self-Medication Release Form

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

has been instructed in the proper use of the following medication procedures: \_\_\_\_\_

\_\_\_\_\_  
We, (Physician signature) \_\_\_\_\_

And (parent/guardian signature) \_\_\_\_\_,

request that (Child's name) \_\_\_\_\_ be permitted to keep the medication in his/her personal possession, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

NOTE: This form must be completed *in addition* to the routine district medication form for those students who request permission to carry their own medication on campus.