MARION COUNTY SCHOOL DISTRICT
2025-2026
PARENTAL PERMISSION/RELEASE OF LIABILITY FOR STUDENT
SELF MONITORING or SELF MEDICATING OF MEDICAL CONDITION

I authorize my child to **self-monitor and /or self-medicate** a medical condition as ordered by his/her health care provider as described in the Health Care Practitioner Authorization, while at school, on school grounds, at school sponsored activities, in transit to or from school or school sponsored activities, or during before or after school activities on school property.

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

I understand that the School District, its employees and agents, are not liable for an injury arising from a student's self-monitoring or self-administration of medication. I agree to indemnify and hold harmless the school district, its employees and agents, against a claim arising from my child's **self-monitoring and or self-administration** of medication related to a medical condition.

I authorize the school to share the student's Individual Health Care Plan with school staff personnel who have legitimate need for knowledge of this information.

_____ _____
Child's Name Child's Date of Birth

_____ _____
Signature of Parent/Guardian Date

HEALTHCARE PRACTITIONER AUTHORIZATION

I verify that the above named student's medical condition is such that **self-monitoring and /or self-medicating** at school, on school grounds, at school sponsored activities, in transit to or from school or school sponsored activities or during before or after school activities on school operated property is appropriate.
I further verify that the student has been trained and has demonstrated competency in self-monitoring and or self-medicating of the below named condition.

Medical Condition:

☐Yes, I give this student permission to **self-monitor**
☐Yes, I give this student permission to **self-medicate**

Self – Monitoring Orders:

Self-administration medication orders:

_____ _____
Signature of Health Care Provider Date