H-3-9	**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY** **STUDENT RETENTION OF MEDICATION**	OMB Control No: OMB approval expires:

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section, 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921-932 (Defense dependents' education system).
PRINCIPAL PURPOSE: Obtain health related information about a student enrolling or enrolled in Department of Defense Education Activity schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education.
ROUTINE USES: Routine Use: DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a (b) (1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a (b) (2-12), and the "Blanket Routine Uses," published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.
DISCLOSURE: Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

Permission for Student to Retain Control of Medication

All sections must be completed and signed.

Section 1 To be completed by Primary Care Manager/Provider

Name of student: _____ DOB: _____ Grade:_____

Diagnosis: _____ Duration of treatment: _____

Medication: _____ Dosage: _____ Route: _____

Possible side effects: _____

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:_____

Back-up medication needs to be kept in school health office: (Circle one) YES / NO

What student should do if the expected results are not obtained and in case of adverse reaction: _____

_____

I have instructed the student and the sponsor/parent/guardian 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 sponsor/parent/guardian 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.**

PCM signature & Stamp: _____ Phone: _____ Date: _____

Section 2 To be completed by sponsor/parent/guardian and return to school nurse

I have read the physician's statement and hereby consent to my dependent's retaining possession at all time of the above prescribed medication. I understand, and have informed my dependent, 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. **I will provide extra medication to be kept in the school nurse's office as backup for the medication carried by my dependent.**

Sponsor/Parent/Guardian 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/teacher/coach that will help evaluate and monitor the effects of my medication. **During school hours I will take my medication under the supervision of the designated school personnel. Designated by the school nurse and principal.**

Student's signature: _____ Date: _____

Instructions reviewed with student by nurse. School nurse's signature: _____