REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Student: _____ DOB: _____
Class of: _____

PARENTAL REQUEST: I, the parent/guardian of _____, authorize the Principal and School Nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the school, school nurse and principal against any claims arising out of the self administration of medication by the student.

I agree to bring a weekly supply of the medication to the school nurse. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Address Telephone #

PHYSICIAN'S STATEMENT

In order to protect the health of _____, it is necessary for him/her
Student's name
to have the following medication during school hours.

MEDICATION:

DOSAGE:

TIME TO BE ADMINISTERED:

PURPOSE OF MEDICATION:

LIST ANY POSSIBLE SIDE EFFECTS WHICH MIGHT BE EXPECTED:
_____

DIAGNOSIS: _____

_____ _____
Signature of Physician Date

_____ _____
Print Physician Name Telephone #

_____
Street Address, City, State, Zip