Request for Self-Administration of Medication

STUDENT'S NAME________________________________ School_______________________

DATE OF BIRTH__________________________________ Grade______________________

To Be Completed by Physician: (Please Print)

I am requesting that the above named student be allowed to self-administer the following medications:

Name of Medication____

Diagnosis for which medication is given:__________________________

If DAILY, at what time?_________________________________

If "WHEN NEEDED," describe indications:________________

How soon can it be repeated?____________________________

Possible side effects and/or special precautions to be taken:________

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Length of time this medication is prescribed:_____________________

Conditions under which self-administration will take place:

___ Independently. Child has been trained and is proficient in self-administering medication.

___ Under the supervision of school nurse.

Medication should be:

___ stored in the nurse's office or designated area.

___ in the possession of student.

_______________________________ Physician's Name (print)

_______________________________ Physician's Signature

_______________________________ Telephone Number

_______________________________ Date

To Be Completed by Parent: I give my permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.
The medication is to be provided by me in the original labeled container. To my knowledge my child is not allergic to this medication.
I hereby release and hold harmless the Board, its agents, and employees from any and all liability for injuries or other damages which result from administration of the medication.
I will have these forms renewed every school year.

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Parent/Guardian's Signatures)

Date_________________________ School________________________