MEDICATION SELF-ADMINISTRATION FORM

Today's Date: _____

Student's Name: _____ Age: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher/Advisor/Homeroom: _____

PARENT/GUARDIAN AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I give permission for my child to self-administer the medication described below, in the original container. I acknowledge that the School District and its employees and agents shall incur no liability as a result of my child's self administration of this medication and agree to indemnify and hold harmless the School District and its employees and agents from legal fees, costs, and any potential damages arising from my child's self administration of medication. I give the school nurse permission to contact the physician, healthcare provider and/or pharmacist with any questions concerning the medication. If maintaining a supply of medication with the school nurse or trained personnel, I understand and agree that it is my responsibility to resupply the medication when the initial supply has been depleted. I also understand that I am responsible for providing a school medication consent form that is signed by my child's provider.

Medication	Strength	#Amount to be given	Time to be given

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Daytime Phone Number

<u>INITIAL MEDICATION SUPPLY</u>

_____ # of Pills/Tablets/Capsules/ML_____
Name of Medication

_____ _____
Nurse Signature Date