STUDENTS **3510F1**

Authorization for Self-Administered Medication

Student's Name: _____ Grade: _____ DOB: _____

Parent/Guardian Name: _____

Telephone: (Home): _____ (Work): _____

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

_____ _____
Parent/Guardian's Signature Date

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THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

I am recommending that the above named student be allowed to self-administer the following medication.

Name and Purpose of Medication: _____

Identification of Chronic Medical Problem: _____

_____

Prescribed Dosage to be Taken: _____

Length of Time Medication Must be Taken: _____

Possible Side-Effects and/or Special Precautions to be Taken: _____

_____

Conditions Under Which Self-Medication Will Take Place:

_____ **Independently** (*Child must have had training and be proficient in self-administering medication.*)
Trainer's Name: _____

Date of Training: _____

_____ **Under the supervision of a school nurse**

Medication should be: _____ Stored in the Health Office

_____ In the possession of the student

_____ _____
Type or Print Physician's Name Physician's Signature

_____
Date