Permission for Self-Administration of Medication

Name of Student _____

School_____ Grade _____

Teacher _____

Name of Prescribing Physician _____

Medication _____ Dosage _____

Date Started _____

Duration Medication to be Administered: _____

Conditions under which the medication is to be given: _____

_____

Any additional circumstances under which the medication is to be given: _____

_____

I hereby give my permission for _____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

My child has been instructed on self-administration of the medication and is authorized to do so in school.

_____

Signature of Parent or Guardian

Date _____

_____

Signature of Health Care Provider

Date _____

NOTE: Medication must be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage, and times to be administered.

Updated 8-1-18