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.