

## 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.**