AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

(TO BE KEPT CONFIDENTIAL UPON COMPLETION)

NAME OF STUDENT: ______________________________ GRADE: ______

DIAGNOSIS/ILNESS: ____

MEDICATION: ______________________________

DOSAGE: ________________________ FREQUENCY: ____________________

SPECIAL DIRECTIONS: ____

POSSIBLE SIDE EFFECTS: ____

* *

I certify that the above information regarding this student is correct, that administration of the medication to this student is necessary, and that the student has received appropriate instruction to self-administer the medication.

______________________________ ____________________

(Signature of Prescribing Physician) (Date)

______________________________ ____________________

(Address) (Phone)

* *

I/we authorize the principal and the school nurse to permit the student to self-administer the above medication as indicated. I/we understand and agree that the school, the school nurse and the principal shall not be liable for any injury to the student resulting from the self-administration of the medication as authorized by my signature below.

______________________________ ____________________

(Signature of Parent/Guardian) (Date)

______________________________ ____________________

(Signature of Parent/Guardian) (Date)