PARENT/GUARDIAN AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I give permission for my child to self-administer the medication described below, in the original container. I acknowledge that the School District and its employees and agents shall incur no liability as a result of my child's self-administration of this medication and agree to indemnify and hold harmless the School District and its employees and agents from legal fees, costs, and any potential damages arising from my child's self-administration of medication. I give the school nurse permission to contact the physician, health care provider and/or pharmacist with any questions concerning the medication. If maintaining a supply of medication with the school nurse, I understand and agree that it is my responsibility to resupply the medication when the initial supply has been depleted.

Student Name:_____ DOB:_____ Grade:_____
School:_____
Medication(s):_____
Dose:_____ Strength:_____ Time(s) of Administration:_____

Parent/Guardian Signature:_____ Date:_____
Print Name:_____ Phone Number:_____

INITIAL MEDICATION SUPPLY:

Name of Medicine:_____ # of pills/tablets/capsules/ml:_____
Nurse Signature:_____ Date:_____

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

(To be Completed by Physician)

I am recommending that the student identified below be allowed to self-administer the following medication at school:

*Student's Name:*_____ *DOB:*_____ *Grade:*_____
*Name of Drug:*_____ *Dosage:*_____
*Diagnosis/Reason for Medication:*_____
*Possible Side Effects:*_____
*Time(s) to be Administered:*_____ *Duration of Use:*_____
*Physician's Signature:*_____ *Date:*_____

Please Print or Stamp:

Physician's Name
Address
Phone Number