REQUEST FOR SELF ADMINISTRATION OF MEDICATION

Last Name: _____

First Name: _____

Grade _____ D.O.B. _____

Asthma Inhalers _____Insect Sting Kit _____

To Be Completed By Physician: (Please Print)
I am requesting that the above-named student be allowed to self-administer the following medications:

Name of medication: _____

Diagnosis for which medication is given: _____

Prescribed dosage and time to be taken: _____

If daily, at what time: _____

If "when needed," describe indications: _____

How soon can it be repeated: _____

Possible side effects and/or special precautions to be taken: _____

_____

Length of time this medication is prescribed: _____

Conditions under which self-administration will take place:

☐ Independently. Child has been trained and is proficient in self-administrating

☐ Under the supervision of school nurse/school staff

Medication should be: ☐ stored in the nurse's office or designated area

☐ in the possession of student

_____ _____
Physician's Name (print) Physician's Signature

_____ _____
Telephone Number Date

To be completed by parent: I give permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container. To my knowledge my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damage which may result to the student, his/her servants and representatives which may result from administration of the medication.

_____ _____
Parent/Guardian Signature Date