Permission for Self-Administration of Medication

Name of Student ____

Grade ____________________________________ Teacher _________________________________

Medication ____

Purpose ___________________________________ Dosage ___________________________________

Date Started _________________________________

Conditions Under Which The Medication Is To Be Given: _______________________________________

____

Any additional circumstances under which the medication is to be given: _________________________

____

Length of time medication is prescribed: ____

Parent/Guardian Statement

I hereby give my permission for __________________________________ to administer the above 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 medications. My child has been instructed on self-administration of the medication and is authorized to do so in school.

____ Date:___________________________________

Signature of Parent/Guardian

Physician/Physician Assistant/Advanced Registered Nurse Statement

I hereby verify the above information and further state that the above named individual has demonstrated to me his/her knowledge concerning the medication and his/her ability to use the medication and any device necessary to administer such medication as prescribed.

____ Date: _____________________

Signature