Parent / Guardian Request for Student Self-Administration of Medication

Student's Name: ____________________________ Grade: __________

Teacher / Advisor: _____________________________

Name of Medication: ___________________________ Dose: _________

Reason for Medication: __________________________ Frequency: __________

Allergies: ______________________________________

Date to begin medication: __________ Date to end medication: __________

Physician Name: _____________________________ Phone #: __________

Comments or Special Instructions: ________________________________

_________________________________________________________________

I am requesting that my child, __________________________, be allowed to self-administer the medication listed. I understand that my child is responsible for this medication and for administering it to him/herself in a safe manner. No record of administration will be kept at the school and my student has been instructed to go to the clinic if, after two doses of medication, there is no improvement. I understand this request is valid only for the current school year.

Parent / Guardian Name: ______________________________________

Phone #: (H) __________ (W) __________ (C) __________

Parent / Guardian Signature: __________________________________ Date: ______

Clinic Nurse Signature: _________________________________________ Date: ______