Request for Student Self-Administration of Medication

PK Yonge
Developmental Research School
at the University of Florida

Student's Name:_____Grade:_____

Teacher/Advisor: _____

Name of Medication: _____Dose:_____

Reason for Medication: _____Frequency: _____

Allergies: _____

Date to Begin Medication: _____Date to End Medication: _____

Comments /Special Instructions: _____

_____

_____

Physician's Name: _____Phone:_____

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 by the school and my child 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: _____

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