Request for Student Self-Administration of Medication

PK Yonge
Developmental Research School
at the University of Florida

Student 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 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 themself 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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