

**AUTHORIZATION FOR SELF-ADMINISTERED and EMERGENCY MEDICATION
(One Release per Medication)**

Student Name: _____ Birth Date _____

Address: _____

School: _____ Grade: _____ Teacher _____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I give permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for all legal fees or costs and any potential damages arising out of any claims brought by the above-named child or anyone else regarding self-administration of this medication.

Parent/Guardian's signature _____ Date _____

THE FOLLOWING ARE TO BE COMPLETED BY THE LICENSED HEALTH CARE PRACTITIONER:

I am recommending that the above-named student be allowed to self-administer the following medication.

Name and purpose of medication _____

Identification of chronic medical problem _____

Prescribed dosage to be taken _____

Length of time medication must be taken _____

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

Conditions under which self-medication will take place (Please Check One)

☐ **Independently** (Child must have had training and be proficient in self-administering medication)

Trainers Name: _____ Date of Training: _____

☐ **Under the supervision of a school nurse/designee**

Medication should be (Please Check One)

☐ **Stored in the office**

☐ **In the possession of the student**

Type or Print Licensed Health Care Practitioner's

Name: _____

Licensed Health Care Practitioner's

Signature _____ Date: _____

Building Principal's Signature _____ Date _____