AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

(To be CONFIDENTIAL upon completion)

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS / ILLNESS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

SPECIAL DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

****

I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary, and that the student has received appropriate instruction to self-administer the medication.

_____ _____

Signature of Prescribing Physician Date

_____ _____

Address Phone

****

I / We authorize the Principal and the school nurse to permit the student to self-administer the above medication as indicated. I / We understand and agree that the school, the school nurse and principal shall not be liable for any injury to the student resulting from the self-administration of the medication as authorized by my signature below.

_____

Signature of Parent / Guardian

_____

Name of Parent / Guardian (PRINT)

_____

Date

APPENDIX "B"