



LAKELAND JOINT SCHOOL DISTRICT #272

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***Physician and Parental/Guardian Authorization Form for
Student Self-Administration of Medication***

PHYSICIAN SECTION

Name of Student

Birth Date

School Name

School Year

The above named student has _____

Name of Disease, Syndrome, and Condition for which this medication is needed.

I am requesting the above named student may carry on their person, and self-administer the following medication during school hour's and extracurricular school activities.

MEDICATION

Name of Medication

Type of medication

Dosage

Time(s) to be administered

Possible side effects

I certify that _____ has been instructed in the use and self-administration of the above medication(s).

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Print Name of Physician / Care Provider

Signature of Physician / Care Provider

Telephone Number of Physician/Care Provider

Fax Number of Physician/Care Provider

PARENT/GUARDIAN SECTION

I give my permission for my child to self-administer the medication described above. I give my permission to the school to call 911 in the event that my child does not have his/her medication and an emergency situation does arise. I shall indemnify and hold harmless the Lakeland Joint School District and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above name student/child or anyone else.

Print Name

Parent/Guardian Signature

Date

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