ST. GEORGE'S SCHOOL

Parent/Guardian Request to Allow Self-Administration of Medication

(Note: This does not apply to Schedule II medications such as Ritalin, Concerta, Adderall, Vyvanse or other psychotropic medications.)

_____ has been prescribed to following:
(Student Name)

Medication	**Dose**	**Diagnosis**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I request that _____ be permitted to self-administer the above medications

Note: St. George's School does not accept responsibility for any consequences in the event that the student fails to follow the prescribing physician's order(s) for the self-administered medications described above.

Signed: _____ Date: _____
(Parent/Guardian)

School Physician approval_____ Date: _____

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