Request and Release
Self-Administration of Medication by Student
Life Threatening Conditions

The undersigned hereby requests for the child hereinafter named to self-administer the prescribed medication(s) listed hereinafter for treatment of the child's asthma/life threatening condition.

I agree to provide all such medication at my expense. I further agree that according to state law, it is my responsibility to supply the school with an emergency supply of the prescribed medications such as inhaler, epi-pen, insulin, glucagons, etc as needed for life threatening conditions, and that if I fail to do this and my child is without an emergency supply of the prescribed medication, the school is not liable. I further agree that, in the event of any change in the health or condition of the child, I will promptly notify the school and advise whether there is to be any change in the administration of such medication. I further agree that, in the event of a change in the physician for the child, I will obtain from the new physician a new written statement concerning administration of prescription medication to the child. I understand that this *Request and Release* is effective for the school year for which it is granted and **must be renewed by the parent/guardian each subsequent school year.**

I hereby release Independent School District Number 1-69 of Canadian County, Oklahoma the District commonly referred to as Mustang Public Schools, its officers and its employees, from any and all liability resulting from the child's failure to administer the medication indicated below. I further hereby release Mustang Public Schools, its officers and its employees, from any and all adverse effects of this medication and agree to indemnify them, or any of them, against any and all liability, loss or damage they or any of them may incur as a result of the child not properly self-administering the medication.

Name of Child____

Name of Physician____

Condition for which medication is administered:___________________________

Name of Medication Prescribed: ____________________________________

Dosage/Method of Administration: ___________________________________

Timing and Indication for administration of medication:____________________

To be administered until (Date): ______________________ *not to exceed one school year

Other recommendations: _______________________________________

Physician's Statement:

_______ I have instructed ______________________ in the proper use of his/her medication(s), and it is my professional opinion that this child should be allowed to carry and use the above listed medication by him/herself.

_______ It is my professional opinion that ________________ should **not** carry his/her medication him/herself.

______________________	______________________	__________
Physician's **PRINTED** Name	Physician's **Signature**	Date
______________________	______________________	__________
Parent/Guardian **PRINTED** Name	Parent/Guardian (having legal custody) **Signature**	Date