Request for Student to Possess and Self Administer Medication
School year:_____

A student may possess and self-administer emergency medication for a chronic disease or medical condition ONLY if the parent or guardian annually files this form with the clinic. This form must be signed by the parent or guardian and a physician or nurse practitioner. This form will be valid for one school year only, and a new form filled out each school year.

Parent or Guardian Authorization

I am the Parent / Guardian (circle one) of the student identified below. I authorize MSD of Lawrence Township schools to permit this student to possess and self-administer the medication identified below on school property and during school time.

_____ _____

Student's Name (Please print) Name of medication

_____

Purpose of medication

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name Phone Number

Provider's Statement

I am a licensed physician/nurse practitioner. I provide medical services to _____*(name of student)* and have prescribed _____*(name of medication)* for this patient. I certify that the following statements are true and accurate:

A. An acute or chronic medical condition exists for which the above named medication is prescribed
B. The student named above has been given instructions as to how to self-administer the medication; and
C. The nature of the disease or medical condition requires emergency administration of the medication

_____ _____

Provider's Signature Date

_____ _____

Provider's Name Printed Phone Number

_____

Address

Student's Statement

I agree to use the above medication in accordance with school policies. I will not share this medication with any other students, I will keep it on my person at all times, and I will not use it for any other purpose than stated by my medical provider.

_____ _____

Student's Signature Date