



# Marion Cross School

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Shawn Gonyaw, *Principal*  
Greg Bagnato, *Coordinator of Student Services*

## AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL

Name and DOB of student: \_\_\_\_\_

Condition for which the medication is administered: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose & method: \_\_\_\_\_

Time(s) of administration: \_\_\_\_\_

Duration of medication (limit to 1 school year)

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

In my opinion, this student shows capability to carry and self-administer the above medication.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name

\_\_\_\_\_  
Physician Phone Number

### Parent/Guardian Authorization

I request that \_\_\_\_\_ be permitted to: carry / self-administer  
(circle one or both)

the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, including the original label indicating the student's name, prescribing health care provider, medication name, date of original prescription, strength and dose of prescription, and directions for use.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name