



Authorization For Self-Carry/Self Administration of Medication/s

Medications can only be self-carried/self-administered at school with written permission from the child's parent or guardian and Health Care Provider. The medication must be in the original bottle with pharmacy label as proof of prescription. Signed permission will expire at the end of the school year.

Student: _____ School Year: _____

Birth Date: _____ Allergies: _____

To Be Completed By Physician:

I hereby attest that this child has been properly instructed, trained, and is competent to carry/administer the following medication:

Name of Medication: _____

Medication Dosage: _____

Time of day for Dose: _____

Possible Reaction or Side

Effects: _____

Signature of Primary Care Provider

Phone Number

Date

To Be Completed By Guardian

I hereby request that school personnel allow my child to self-carry/self-administer the medication described below

Medication: _____ Dose: _____ Frequency: _____

Prescribing Primary Care Provider: _____ Phone Number: _____

I hereby give permission for my child to carry/administer the above medication at school according to school policy and expressly waive and liability on behalf of the school or Healthy Kids Clinic as a result of the administration of the above medication. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the School Nurse regarding my child's medical regime.

Guardian Signature

Phone Number

Date

Emergency Contact

Phone Number

Relationship