Notus School District No. 135

STUDENTS **3510F1**

AUTHORIZATION FOR SELF-ADMINISTERED MEDICATION

STUDENT'S NAME: _____ GRADE _____ DOB _____

PARENT/GUARDIAN NAME: _____ TELEPHONE (HOME) _____
(WORK) _____

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

_____ _____
Parent/Guardian's Signature Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN: I am recommending that the above named student be allowed to self-administer the following medication.

Name and purpose of medication_____

Identification of chronic medical problem _____

_____

Prescribed dosage to be taken_____

Length of time medication must be taken_____
Possible side effects and/or special precautions to be taken_____
_____

Conditions under which self-medication will take place:
____Independently *(Child must have had training and be proficient in self-administering medication)*.
____Under the supervision of a school nurse

Trainer's Name:_____ Date of training:_____

Medication should be: ____Stored in the health office
____In the possession of the student

_____ _____
Type or print physician's name Physician's Signature

_____
Date