Form # 4

PIPER USD 203

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION
Medications prescribed by a health care provider for the treatment of asthma and anaphylaxis only

(Grades 5 – 12 only)

Name of Student ____

School ____ Grade ____________

Medication __________________________________ Dosage _____________

Date medication started ____

Conditions under which the medication is to be taken __________________________
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Length of time medication is to be administered _______________________________
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I hereby give my permission for ______________________ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, its employees and agents, harmless against any claims relating to the self-administration of such medication.

My child has been instructed on self-administration of the medication, and he/she is authorized to do so in school.

Signature of Parent or Guardian

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Date ______________________

Signature of Health Care Provider

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Date ______________________