

**MEDICATION PERMISSION SLIP  
2020 - 2021**

Date: \_\_\_\_\_

**The Stillwater Township School nurse has my permission to administer medication to:**

Name of Student/Grade: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be Given/Frequency: \_\_\_\_\_

Duration: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Possible side effects: \_\_\_\_\_

**Please check one:**

- The student requires medication while on class trips.
- It is **not** necessary to provide medication while on class trips.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Stamp:

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*Please note – the medication must be brought to school by the parent/guardian and must be in the original container and appropriately labeled by the pharmacy\*\*\***

**STILLWATER TOWNSHIP SCHOOL  
REQUEST FORM FOR MEDICATION SELF-ADMINISTRATION  
2020-2021**

**Part 1 - to be completed by the Primary Care Provider:**

Name of Student/Grade: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be Given/Frequency: \_\_\_\_\_

Duration: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Possible side effects: \_\_\_\_\_

I certify that \_\_\_\_\_ has a potentially life threatening

**(Student's name)**

condition that qualifies him/her to self-administer and/or carry his/her own medication. This child is being treated by me for \_\_\_\_\_

**(diagnosis)**

and that the medication can be self-administered. Furthermore, the student is capable of, and has been instructed in the proper method of self-administration of this medication.

Date: \_\_\_\_\_

Physician signature and Stamp: \_\_\_\_\_

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**Part 2 - To be completed by PARENT:**

I request permission for my child, \_\_\_\_\_ to self-administer the above mentioned medication, as per permission of my family physician.

If permission is granted by the school nurse and chief school administrator, the school district, the Board of Education, and its employees shall incur no liability as a result of any injury arising from the self-medication by my child.

Permission may be revoked if the student proves to be incapable of self-administering medication in the school setting.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Asthma and anaphylactic reactions are examples of potentially life threatening illnesses\*\***