



Permission to Self-Administer Prescription Medication

Medications prescribed by a healthcare provider for the treatment of asthma and anaphylaxis only

Name of Student _____

Name of School _____ Grade _____

Medication _____ Dosage _____

Medication start date _____ Duration _____

Conditions under which the medication is to be taken _____

Date _____ Physician's Signature _____

Anticipated Side Effects _____

I consent to my child 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 at school.

Signature of Parent or Guardian

Date

Signature of Healthcare Provider

Date

Note: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the student, name of medication, dosage, route of administration, directions or interval for the drug to be given, expiration date of the medication, name of licensed healthcare provider prescribing the medication, and pharmacy contact information.

Written authorization to administer prescription drugs will expire automatically at the end of each school year. A new authorization will be required annually.

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