AGUA FRIA UNION HIGH SCHOOL DISTRICT

Consent to Self- Administer Prescription Medication at School

(medical provider recommendations must be attached on letterhead or prescription form)

Date: ____________

Student Name: ____ Date of Birth: _________ Grade:________

I hereby request and give my consent for my child, _______________________________, to self-administer their prescribed medication for the period from ____________________________ to ______________________________.

The medication is to be in the original container, labeled, and given in the following manner:

1. Name of medicine and prescription number: ____
2. Dose to be administered: ____
3. Time of Day to be administered:____
4. Expected duration of treatment: ____
5. Prescriber's Name (must be on the label): ____
6. Indication (reason) for medication: ____

____ Printed Name (Parent/Guardian)

____ Signature (Parent/Guardian)

____ Phone Number (Parent/Guardian)

____ Date

____ Teacher(If needed)

____ Room No.

Comments:

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THE SCHOOL MUST BE NOTIFIED IMMEDIATELY IN WRITING OF ANY CHANGE IN MEDICATION