OKEMOS PUBLIC SCHOOLS

Student Health and Safety

Consent for Student to Self-Administer Medication Form

Student Information

Student's Name: _____

Date of Birth: _____ Grade: _____

Medication Name: _____ Dose: _____

Administration Method: _____ Administration Time/frequency: _____

If "as needed," under what conditions is the medication to be administered:

_____

Relevant side effects: _____

_____

Healthcare Provider Information

Name/Title: _____

Address: _____

Telephone: _____ Fax: _____

Please attach to this form the Student's healthcare provider's written authorization for the Student to possess and administer this medication.

Parent/Guardian Consent

I, _____, give permission for my Student to possess and administer medication in accordance with this form and applicable Policies. I acknowledge that Board Policy requires that I inform the District of any changes to the healthcare provider's medication instructions immediately.

Parent's/Guardian's Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(Please circle which phone number you would like District staff to call first.)

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