



Consent to Carry & Self Administer Medication

To be completed by parent/guardian

Student Name		DOB		Grade	
Address		City		State	
Emergency Contact		Phone (H)			
Phone (C)		Phone (W)			

To be completed by prescribing provider

Provider Name		Phone (O)			
Address		City		State	
Prescribed medication					
Reason for medication / Description of condition					
How/when medication should be used at school					
Anticipated length of treatment (as appropriate)					

_____ has a condition that is treated with the above named medications. He/She has been instructed in the proper use of the above medication. He/She is capable of administering their medications, either at school or at any school-related event or activity. Any change to the above medication, dosage or recommended regimens will be accompanied by an updated version of this form.

Prescribing Provider's Signature: _____ Date: _____

To be completed by parent/guardian

I give permission for _____ to carry and self-administer the above named medications at school or any school-related activity. I release the school district and its employees from liability from an injury arising from the carrying or self-administered use of the above medication while on school property or any school-related event or activity. I agree to indemnify the school district and its employees from any claim arising from the carrying or self-administered use of the above named medication while on school property or any school-related event or activity.

Parent/Guardian Signature: _____ Date: _____

To be completed by the student

I have been instructed in the proper use of my medication. I am capable of carrying and self-administering my medication. I agree to carry and use my medication in the proper manner and will not use my medication except for its intended purpose. I understand that I am responsible for the safeguarding of the carried medication.

Student Signature: _____ Date: _____