Permission for Self-Administration of Medication

Name of Student: _____

School: _____ Grade: _____Teacher (for elementary):_____

Medication: _____ Dosage:_____

Date Start: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Length of time medication is to be self-administered: _____

Conditions under which the medication should be self-administered:

_____

Any additional circumstances under which the medication should be self-administered:

_____

I hereby give my permission for my student to administer the above medication at school per medication direction and/or orders. 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, and 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 is authorized to do so in school.

Signature of Parent or Guardian: (Note: Parental permission must be renewed annually)

_____ Date: _____