



Health Services Department

**Parental Annual Authorization for
Student Self-Administration For
Emergency Medications/Treatments**

Student Name: _____ School Year: _____

Grade: _____

Medication/Treatment: _____

I, the parent or legal guardian of the student listed above, give permission for my child to carry and self-administer the above-listed medications/treatments. I have instructed my child to notify the school staff if medications/treatments are used, but the condition has not improved. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the self-administration of medication by my child. This permission can be revised if there is evidence that the student is not administering medication appropriately.

Signature of Parent or Legal Guardian: _____

Printed Name of Parent or Legal Guardian: _____

Date: _____

Note: Other forms that are required to be completed in addition to this form:

- Medication Authorization Form
- Emergency Action Plan Annual Parental Review

Updated February, 2026