Unified School District 322
Onaga-Havensville-Wheaton

Permission for Medication ***Self-Administration***

Name of Student: _____ DOB: _____
Emergency Contact: _____ Phone _____ Relationship _____
Ordering Provider _____ Provider's Phone _____

Medication: _____ Dosage: _____
Medication start date: _____ Medication end date: _____
Time medication is to be administered at school: _____
Reason for Medication (Diagnosis): _____

Additional comments: _____
_____
_____

I hereby give my permission for the student listed above to take the above medication at school as ordered. I understand that it is the parents/guardians responsibility to furnish the medication. I acknowledge that the school incurs no liability for any injury resulting from this self-administration of medication and agree to indemnify and hold the school, its employees (Office Manager), school nurse, or other agents, harmless against any claims relating to the self-administration of such medication. The medicine is to be kept in the area marked below with the student's name clearly printed on the label, and this permission form in the same area.

_____ **in the OHS office (or)** _____ **with the student in their belongings**

My child has been instructed on self-administration of the medication and is competent on the above medication and diagnosis. This authorizes that he/she is capable to safely and effectively administering and storing the medication, as ordered above, in the school setting or during school related activities.

_____
Signature of Parent/Guardian Date

_____
Signature of Health Care Provider Date

_____
School Nurse Reviewed - Date