Germantown SCHOOL DISTRICT

Empower and Inspire Every Student to Success

PARENTAL CONSENT FOR SELF ADMINISTRATION OF MEDICATION

(Physician Signature Required for all Prescribed Medications)

Date: _____ **School:** _____

Name:_____ is in need of medication during school hours. I hereby give permission for my child to self-administer the below listed medication. (Please use one sheet per medication).

Name of Medication: _____ (**Please Circle**) Prescription / Non-Prescription

Reason for Medication: _____

Dosage: _____ **Time of Administration:** _____

How to be Given (i.e. with water, with food): _____

Physician: _____ **Clinic:** _____

Physician Phone: _____ **Fax:** _____

Parent/Guardian Initials

_____I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding self-medication administration.

_____I accept complete responsibility for my child's self-administration of medication and release the District from any liability. I understand that my child will be held responsible for the proper use of medications carried on his/her person for self-administration purposes. Appropriate disciplinary action will take place if any medication is transferred to another student by my child.

I understand no medication will be self-administered at school without full compliance of the above stated terms and conditions. (Physician signature required for all prescribed medication to include inhalers)

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Physician Signature **Date**