

USD # 415

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student _____

School _____ Grade _____

Teacher (s) _____

Medication _____ Dosage _____

Date Started _____

Conditions under which the medication can be taken:

Length of time medication is to be administered:

I hereby give my permission for _____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs to 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 it authorized to do so in school.****

Signature Parent/Guardian: _____ Date _____

Signature of Health Care Provider: _____ Date _____

Approved: