BLOCK ISLAND SCHOOL

AUTHORIZATION FOR
SELF-CARRY/SELF-ADMINISTRATION OF MEDICATION

Student's Name _____ DOB _____

Grade/Teacher _____

To be completed by parent/guardian:

I hereby give my consent for my child to self-carry/self-administer the medication ordered below:

_____ _____
Date Parent/Guardian

_____
Telephone No.

To be completed by physician:

Diagnosis for which medication is ordered: _____
Name of medication _____
Dosage _____ Method of Administration _____
Length of time this ordered _____

I agree/disagree with this student self-carrying/self-administering the above stated medication.

_____ _____
Date Physician

_____
Address

_____ _____
Date School Administrator