EASTON VALLEY
COMMUNITY SCHOOLS
www.EastonValleyCSD.com

PARENTAL AUTHORIZATION FOR THE SELF ADMINISTRATION OF MEDICATION

STUDENT'S NAME_____**DATE**_____**GRADE**_____
MEDICATION_____
NEED FOR MEDICATION_____

I hereby authorize my child to self administer his/her medication as he/she has shown the competency to do so.

I hereby agree to:

*Personally ensure that the medication is in the **original labeled container** it was dispensed. The medication label contains the student's name, name of the medication, directions for use and date dispensed.

*A copy of the original Doctor's prescription or a note from the physician must accompany this form.

*Personally ensure that the medication will be kept in the student's possession.

*If it is a controlled substance/narcotic, it needs to be in the locked cabinet in the Nurse's office.

*Submit this request to the school nurse.

PARENT/GUARDIAN SIGNATURE_____
DATE_____**PHONE NUMBER**_____
ALTERNATE PHONE NUMBER_____