Meridian ISD Health Program

Self-Administration of Medication

Name of student:____

Name of Prescribing Provider:________________________________

Contact Information for Provider:____

____

Description of condition/reason for medication:____

____

Prescribed medicine and dosage:____

____

How/when medication should be used at school:____

____

Anticipated length of treatment:____

____

Parental/Provider Self-Administration Assessment and Consent

(Student)________________________________has_________________________, and is treated with prescription medication. He/she is/is not (circle one) capable of administering their own medication, both on school grounds and at school-related events and activities. Any changes to the above medication, dosage or recommended regimen will be accompanied by an updated version of this consent.

____ ___________________________

Parent/Guardian Signature Date

____ ___________________________

Healthcare Provider Signature Date