Hebron School District **Form A**
08/2006

SELF-MEDICATION RELEASE FORM

PART A: TO BE COMPLETED BY THE PHYSICIAN OR DENTIST

It is my opinion that _____ is capable of self-administering the following medication:

Medication: _____

Dosage and Method of Administration: _____

Frequency: _____

To be given from _____ to _____

Diagnosis: _____

Relevant Side Effect: _____

_____ It is my recommendation that this child shall have the medication available to him/her in school and on school related trips.

_____ It is my recommendation that this child may carry the above medication on his/her person during school, on school related trips and to/from school.

Signature of Physician/Dentist: _____

Address: _____

Telephone: _____ Date: _____

PART B: TO BE COMPLETED BY THE PARENT

I give my permission for my child _____ to self-administer the medication as ordered by his/her physician/dentist. I understand this medication shall be available in school and on school related trips or I understand that my child will carry the medication on his/her person (see Form B).

B.1. While he/she is in school, the medication shall be stored in the Health Room or with the teacher, unless otherwise specified by the physician/dentist. I assume responsibility for breakage, student misuse and his/her ability to self-administer the medication. In the event that my child is unable to self-administer the medication, I give permission for trained school personnel to administer it.

Signature of Parent/Guardian: _____

Address: _____

Telephone: _____ Date: _____