

**Permission for Self-Administration of Medication
Centre USD 397**

Name of Student: _____ Grade: _____

School: _____ Teacher: _____

Medication: _____ Dosage: _____

Date Started: _____

Conditions under which the medication is to be given: _____

Any additional circumstances under which the medication is to be given:

Length of time medication is to be administered: _____

I hereby give my permission for _____ (name of student) 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 no 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 is authorized to do so in school.

Signature of Parent or Guardian (Note: Parental permission must be renewed annually):

_____ Date: _____

Parent Name (Please Print): _____

Signature of Health Care Provider: _____

Health Care Provider Name (Please Print): _____

Date: _____