Permission For Self-Carry/Self-Administration Form

Student Name:	Date of Birth: Grade:	
School:		
HEALTH CA	ARE PROVIDE	R
MEDICATION:	Medication Allergies:	
Dose:	Route:	Time:
Purpose of Medication		
Through my consultation with the below named parent/guardian, as determined that the Student is able to identify his/her correct medic medication ("Medication"), and has knowledge of the required dosa knowledge of his/her condition and is sufficiently responsible and a school day. The Student has been instructed in the purpose, approof self-administering the Medication. A new form must be complete medication if student is having difficulty.	cation, demonstrate cage and timing/freque able to properly carry appriate method, and f	orrect self-administration of the above listed ncy of use of the Medication. The Student has and self-administer the Medication during the requency of use of the Medication and is capable
Health Care Provider's Signature	Date (good	for one year unless noted)
Health Care Provider's Printed Name	Phone and	Fax Number
PA	ARENT	
I agree to and have discussed the following with my c	child:	
It is understood that the Medication will be self-admin accommodation to, the undersigned parent(s) or guar center/school and its personnel from any and all claim to an act or omission of the Student's use of the Medi use and it will be kept in the original package with eith name written on it. I give permission for this informatic care provider may be contacted if necessary.	rdian(s). The und n(s), which they n ication. I will be s ner a prescription	dersigned hereby agree(s) to release the low have or may hereafter have relating supplying the medication for my child's label or if over-the-counter, my child's
	Date:	Phone:
Parent/Guardian Signature		
STU	UDENT	
I agree to be responsible for possessing and self-adm I agree to notify the school health office if I am having I agree that the medication is only for my use, and I w I agree that failure to abide by the terms of this agreet and/or loss of the ability to self-carry. Middle School and High School may carry a one-day Middle School and High School may carry one day su	symptoms or dif vill use it accordin ment and applica supply of over-th	ficulty. g to the instructions. ble policy will result in disciplinary action e-counter medication without this form.
Student Signature:		Date:
School Nurse Review:		Date: