



SELF ADMINISTRATION OF MEDICATION AT SCHOOL

Policy #325

Student Name: _____

School Name: _____

Academic Year: _____

Name of Attending Physician: _____
(print)

Name of Medication: _____

Details of Self Administration of Medication: _____

Physician's Authorization: _____
(Signature)

(Date)

I request that the school allow my child to self-administer the medication prescribed on this form:

Location of medication: _____

Parental Authorization: _____
(Signature of Parent/Guardian)

(Date)