SELF - MEDICATION ADMINISTRATION RELEASE FORM

Medication, including those for self-medication, must be properly labeled.

Student_____ Date_____

Date of Birth_____Grade_____ Teacher_____

Allergies_____

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Medication_____

Dosage_____Time To Be Administered_____

Reason For Medication_____

Possible Side Effects_____

Special Instructions_____

I being the physician of _____ has my permission to carry and administer

his/her own medication.

Physician/NP Signature: _____

TO BE COMPLETED BY PARENT

In Case of Emergency:

Hospital to be called_____Phone_____

Parent_____Phone_____

Alternate_____Phone_____

Health Care Provider_____Phone_____

I being the parent/guardian of _____ has my permission to carry his/her inhaler/

Auto-inject able epinephrine (epi-pen) while in school, or at an off- site sponsored activities.

No personnel of the Nemo Vista School District shall be liable for injury to a student caused by his/her use of the prescription inhaler or self-administration of medication.

Parent/Guardian Signature_____Date_____

Relates to Board Policy 4.35 Handbook page 74