

**Payette School District No. 371**

**STUDENTS**

**3510F1**

Authorization for Self-Administered Medication

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Telephone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

.....  
**THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:**

I am recommending that the above named student be allowed to self-administer the following medication.

Name and Purpose of Medication: \_\_\_\_\_

Identification of Chronic Medical Problem: \_\_\_\_\_

Prescribed Dosage to be Taken: \_\_\_\_\_

Length of Time Medication Must be Taken: \_\_\_\_\_

Possible Side-Effects and/or Special Precautions to be Taken: \_\_\_\_\_

**Conditions Under Which Self-Medication Will Take Place:**

\_\_\_\_\_ **Independently** (*Child must have had training and be proficient in self-administering medication.*)

Trainer's Name: \_\_\_\_\_

Date of Training: \_\_\_\_\_

\_\_\_\_\_ **Under the supervision of a school nurse**

Medication should be: \_\_\_\_\_ Stored in the Health Office

\_\_\_\_\_ In the possession of the student

\_\_\_\_\_  
Type or Print Physician's Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date