Stephen – Argyle Central

Self-Administration of Medications

School Year: _____

Student Name:	Grade:
Parent/Guardian Phone # (please specify)	

To Be Completed By Health Provider

It is in my professional opinion that the student named above is capable of carrying and self-administering the following medication:

Medication		Mediation	
Dose / Route		Dose / Route	
Frequency		Frequency	
Other Info		Other Info	

I recommend self-administration of the above mediation(s) for the treatment of_____

Symptoms should be checked by the Licensed School Nurse:
_____ daily _____ weekly _____ monthly _____ as needed/requested

Comments:

This expires at the end of the school year, unless otherwise noted: _____

Signature of Health Provider: _____Date_____

Printed name and contact information:

To Be Completed by Parent/Guardian

I give my permission for my child to self-carry and self-administer during school hours as prescribed by my child's health provider. Should the need arise I give permission for the Licensed School Nurse to contact the health provider with questions or concerns. I will notify the school of any changes to the above medications, and supply new forms. My child will sign and follow the self-administration agreement. The medication will be supplied in the original prescription bottle/container/syringe with the student's name on it. I release the school personnel from liability in the event that an adverse reaction would occur as a result of taking the medication. If I choose, a supplemental bottle of the medication may be provided and stored in the school office (this must have the original or prescription label on it).

Signature of Parent/Guardian: _____Date:_____