Physician/Parent/Guardian Request for Self-Administration of Medication

Name of Student _____ DOB: _____ Allergies: _____

I am requesting that the above named student may self-administer the following medicating during school hours.

Name of Medication: _____

Dose: _____ **Route:** _____ **Time(s)**_____ **of Medication**

Possible side affects _____

I certify that the student named above has been instructed in the use and self-administration of _____**(name of medication).** He/she understand the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone numbers in the event of a reaction to the medication or an emergency:

Signature of Physician _____Date_____

Print Name of Physician _____

Office #_____

Emergency #_____

Address of Physician _____

Parent Guardian Authorization for Self-Administration Medication

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate. _____Yes _____No.

I the undersigned give permission to the school nurse/designee to administer the above medication as needed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Telephone #'s Home: _____ Cell: _____ Work: _____

If unable to contact – Emergency Person to Contact: _____ *Phone #* _____

OTHS Nurse Signature: _____Date: _____

Student Signature: _____Date: _____