PERMISSION TO SELF MEDICATE AT SCHOOL

_____ needs to self-medicate during the school day.
(Student's Name)

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Time to be given: _____

Effective Date: From: _____ To: _____

Attending Physician: _____

Parent/Legal Guardian Signature: _____

Date: _____

All medication must be in a prescription bottle with the correct labeling (student's name, name of medication, correct dosage) from the pharmacy. All medications will be kept in the School Office and student will come to the school office to receive their dosage at the correct time of the day.