NURSE ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT________________________________GRADE________________

DIAGNOSIS____

MEDICATION____

DOSAGE_________________________FREQUENCY_________________________

DIRECTIONS____

POSSIBLE SIDE EFFECTS____

I authorize the School Nurse to administer the above medication:

______________________________	______________________________
Signature of M.D. Date	Signature of Parent/Guardian Date
______________________________	______________________________
Physician's Street Address	Town & Zip Code
______________________________	__________________
Telephone Number	

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

______________________________	______________________________
Signature of Prescribing Physician	Date
______________________________	______________________________
Address	Telephone Number

****

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurses and other school employees against any claims arising from the self-administration of medication by my child.

Date__________________Parent/Guardian Signature______________________________

BOTTOM PORTION OF THIS FORM TO BE FILLED OUT <u>ONLY</u> IF STUDENT SELF-MEDICATES.