Dietrich School District No. 314

3510F(1) STUDENTS

<u>Authorization for Self-Administered Medication</u>

Student's Name:	Grade: DOB:
Parent/Guardian Name:	
Telephone: (Home):	(Work):
I give my permission for my child to self-admir indemnify and hold harmless the District and it any potential damages concerning self-administ brought by the above named child or anyone els	s employees or agents for legal fees, costs, and tration of this medication arising out of any claims
Parent/Guardian's Signature	Date
THE FOLLOWING IS TO BE COMPLETI	ED BY THE PHYSICIAN:
I am recommending that the above named stude medication.	ent be allowed to self-administer the following
Name and Purpose of Medication:	
Prescribed Dosage to be Taken:	
Length of Time Medication Must be Taken:	
Possible Side-Effects and/or Special Precaution	ns to be Taken:

Conditions Under Which Self-Medication Will Take Place:

_ Independently (Child must have had traini medication.)	ing and be proficient in self-administerin
Trainer's Name:	
Date of Training:	
_ Under the supervision of a school nurse	
Medication should be: Stored in the	Health Office
In the possess	sion of the student
Type or Print Physician's Name	Physician's Signature
	 Date