SPARTA PUBLIC SCHOOLS

Request For Self Administration Of Medication

School _____ Grade _____

Student's name _____ DOB: _____

Parent/Guardian _____ Phone # _____

To be completed by physician (please print)

Identification of medical problem _____

I am recommending that the above-named student be allowed to self-administer the following medication: _____

Prescribed dosage _____

Length of time medication must be taken _____

Possible side effects and/or special precautions to be taken _____

I certify that this student has had training in the use of this medication and is proficient in self-administering.

Physician's name (print) _____ Date _____

Signature _____ Phone _____

To be completed by parent/guardian

I give my permission for my child to self-administer the medication prescribed above. The district shall incur no liability as a result of any injury arising from the use of the medication described above. I further hold the district and its employees or agents harmless against any injury or claims that arise as a result of the self-medication. I understand that this permission must be renewed annually.

Parent/Guardian signature _____ Date _____