HERMON SCHOOL DEPARTMENT
PHYSICIAN'S REQUEST FOR STUDENT
TO SELF-ADMINISTER MEDICATION IN SCHOOL

Student Name____DOB________________________

Name of Medication____

Doctor's Name____

Reason for Medication____

Possible Side Effects____

The above student may have the need for this emergency medication during regular school hours to maintain his/her physical health and has the knowledge and skills to safely possess and self-administer this medication in accordance with the following instructions.

Dosage____

Time(s) to be
Administered____

Duration of Medication____

Other____

I understand that the school cannot accurately monitor the frequency and appropriateness of use when the student self-administers medication, and that the school unit will not be responsible for any injury arising from the student's self-medication.

Doctor's Signature____Date___________________

Parent Signature____Date___________________

The above student has demonstrated appropriate technique to ensure proper and effective use of the above medication.

School Nurse____Date___________________

Student Signature____Date____________________