USD 409 Self-Administration of Medication

Name of student:_____

School: _____ **Grade:** _____

Teacher: _____

Medication: _____ **Dosage:** _____

Date started: _____ **Ending date:** _____

Conditions under which the medication is to be taken:

Any additional circumstances under which the medication is to be taken:

I hereby give my permission for _____(name of student) to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

My child has been instructed on self-administration of the medication, has demonstrated correct technique in the administration of the medication, and is authorized to do so in school.

Signature of Parent or Guardian

_____

date

Signature of Health Care Provider

_____

date