PERMISSION FOR MEDICATION SELF ADMINISTRATION OUTSIDE OF SCHOOL HOURS ON SCHOOL GROUNDS OR AT SCHOOL ACTIVITIES

Student Name _____ Date of Birth _____

School _____ Grade _____

Medication _____ Dosage _____

Purpose of Medication _____

Possible Side Effects _____

Time (s) medication is expected to be taken during the school day: _____

Dates medication may be self-administered: From _____to _____

_____

Physician's Signature REQUIRED

_____

Physician

_____

Address

_____

Phone

I hereby give my permission for _____ (student's name) to keep the above medication with him/her outside of school hours on the school grounds or at school activities and to administer it to himself/herself as prescribed. I understand that this medication is to be kept in its properly labeled original container. My child understands the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. My child also understands that is medications not be distributed to any other student or district employee. I hereby release the School District of Oconee County from any and all liability associated with the self-administration of the above medication.

_____

Print Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

_____ _____

Approved: Principal or Designee Date