Permission for Self-Administration of Medication for Anaphylaxis, Asthma, or Diabetes

Name of Student: _____School: _____

Grade: _____ Teacher: _____

Medication: _____ Dosage: _____

Date Started: _____

The number of times per day the mediation is to be given: _____

The time(s) of day the medication is to be regularly given: _____

The number of days, weeks, or months the medication is to be given: _____

Any additional circumstances under which the medication is to be given: _____

The student has been instructed on self-administration of the medication and is authorized to do so in school. The health care provider states that he/she has prepared a written treatment plan for managing anticipated health crisis and for the medications use by the student during school hours. The following is information contained in the plan, and not included in the above information: _____
_____

_____

_____ _____

Date **Signature of Physician**

I have read the above statement from the Health Care Provider I agree and affirm the said statement, and I hereby give my permission for_____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication in the original labeled container. I further understand and agree that the district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and I agree personally, and on behalf of the student to release, indemnify and hold the school, and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication.

_____ _____

Date **Signature of Parent/Guardian**