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Mary Robinson Cohen, M.A., J.D.
Superintendent and Principal

SELF-ADMINISTRATION OF MEDICATION

Student: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN:

The student named above has a potentially life threatening condition which requires immediate use of medication as detailed below. The student has been instructed in the proper use of the medication by myself or a member of my staff and has successfully demonstrated its use. I feel this student is capable of self-administration of this medication.

Diagnosis for which medication is given: _____

Medication and dosage: _____

Indications for use: _____

Frequency: _____

Possible Side effects: _____

Follow-up care: _____

Physician's Signature: _____ Date: _____

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TO BE COMPLETED BY PARENT/GUARDIAN:

I, parent of _____, request that the Roosevelt Board of Education permit my child to use self-administered medication as detailed above by the physician while on school property or while on a school sponsored activity. I agree to comply with the regulations of the school district and hereby agree to indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the pupil.

I also agree to provide an additional inhaler or Epi Pen, identical to the one which the pupil is authorized to carry, which shall be kept in the school nurse office in accordance with school policy.

Parent's Signature: _____ Date: _____