

**GERMANTOWN SCHOOL DISTRICT
PARENTAL CONSENT FOR
SELF ADMINISTRATION OF MEDICATION
(Physician Signature Required for all Prescribed Medications)**

Date: _____ **School:** _____

_____ is in need of medication during school hours. I hereby give permission for my child to self administer the below listed medication. (Please use one sheet per medication).

Name of Medication: _____ (Please circle) Prescription / Non-Prescription

Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be Given (i.e. with water, with food): _____

Physician: _____ Clinic: _____

Physician Phone: _____ Fax _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding self medication administration.

Parent/Guardian Initials _____

I accept complete responsibility for my child's self administration of medication and release the District from any liability. I understand that my child will be held responsible for the proper use of medications carried on his/her person for self-administration purposes. Appropriate disciplinary action will take place if any medication is transferred to another student by my child.

Parent/Guardian Initials _____

I understand that I cannot provide my child with more than a one day supply of medication. It is understood that the student will not be supervised during self-administration of the medication nor will the student be reminded of the medication schedule.

Parent/Guardian Initials _____

I understand that no medication will be self administered at school without full compliance of the above stated terms and conditions. **(Physician signature is required for all prescribed medication to include inhalers)**

Parent Guardian Signature

Date

Physician Signature

Date