DEPARTMENT OF STUDENT SUPPORT SERVICES
OFFICE OF HEALTH SERVICES

PERMISSION TO CARRY AND SELF ADMINISTER MEDICATION

Date _____ School _____

Student _____ DOB _____ Room _____

Per the St. Louis Public School's policies parents/guardians must sign this statement acknowledging that the school district shall incur no liability as a result of any injury arising from a student's self-administration of medication and that the parent/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the student's self-administration of medication or another student's use of the medication.

This permission form will be reevaluated anytime there are major changes in the student's condition, treatment plan, or anytime the student misuses the medication or shows lack of responsibility in handling the medication.

TO BE COMPLETED BY PARENT:

I, _____, request permission for my child
PRINT NAME – FIRST, MI, LAST
listed above to carry his/her own medications and self-administer as needed.

Parent/Guardian's signature _____

TO BE COMPLETED BY PRESCRIBING PHYSICIAN OR PRACTITIONER:
I advise that the student listed above be allowed to carry and use his/her medication(s) listed below as necessary during the regular school day and that this student has been instructed in the proper use and any possible side effects of the medication.

1. Diagnosis _____ Name of medication_____

Specific time(s) and dose(s) to be taken at school _____

Beginning date _____ Ending date _____

Side effects _____

Restrictions _____

2. Diagnosis _____ Name of medication_____

Specific time(s) and dose(s) to be taken at school _____

Beginning date _____ Ending date _____

Side effects _____

Restrictions _____

Printed Name of Prescribing Physician | Signature of Prescribing Physician | Date

Prescribing Physician's Phone Number | Office Address