SOUTH BEND COMMUNITY SCHOOL CORPORATION
Health Services

SELF-ADMINISTRATION OF MEDICATION FORM

Please Print

Name: _____ Birthday: _____
Last, First Middle Month / Day / Year

School: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN/PRACTITIONER

Name: _____ has the following acute/chronic **Condition:** _____ and has been instructed in the proper use of **Medication Name:** _____. The condition requires emergency administration; therefore, we request that he/she be permitted to carry the medication on his/her person. He/she understands the purpose, appropriate method, and frequency of use of this medication.

Physician/Practitioner's Name (Please Print): _____

Address: _____ Phone: _____

Physician/Practitioner's Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I permit my child to carry the above listed medicine ordered by his/her physician/practitioner. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian's Signature: _____ Date: _____

TO BE COMPLETED BY STUDENT

I understand the purpose, appropriate method, and frequency of use of this medication. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student's Signature: _____ Date: _____

THIS FORM MUST BE COMPLETED IN ADDITION TO THE PERMISSION FOR PRESCRIPTION MEDICATION FORM ANNUALLY.

Rev.: 05/08