

## PERMISSION TO SELF MEDICATE AT SCHOOL

\_\_\_\_\_ needs to self-medicate during the school day.  
(Student's Name)

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Effective Date: From: \_\_\_\_\_ To: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

All medication must be in a prescription bottle with the correct labeling (student's name, name of medication, correct dosage) from the pharmacy. All medications will be kept in the School Office and student will come to the school office to receive their dosage at the correct time of the day.