
PUPIL SELF-ADMJNISTERED MEDICATION

To Physician,

The following pupil has asthma or another potentially life-threatening illness and is capable of and has been instructed in the proper method of self-administration of medication:

STUDENT'S NAME: _____

DIAGNOSIS: _____

MEDICATION AND DOSAGE: _____

SIDE EFFECTS: _____

Medication may be self-administered by the student.

Physician's Signature

Date

Physician's Address

Physician's Phone No.

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WAIVER OF LIABILITY

As the parent of, _____, I agree to comply with the regulations of the school district and in consideration of the privilege extended to me and my child, I hereby agree and acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall 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 understand that this entire consent must be renewed annually.

Parent's/Guardian's Signature