PTAffiliates Permission to Carry and Self Administer Medication

____
Today's Date

Student's Last Name ____ First ____ Middle ____ Birth Date ____

School Site ____ Teacher ____ Room # ____ Grade ____

Physician's Recommendation For Medication

If it is necessary for this child to receive medication at school, please fill in the following information.

Name of Medication	Form (pill, capsule, etc)	Dosage	Time of Day

Precautions if any:______________________________

Medication is to be given by whom?______________________________

IMPORTANT: Please discontinue this request as of the following date:______________________

Physician's Signature ____ Licence No. ____ Address ____ Telephone ____

Parent/Guardian's Signature ____ Address ____ Telephone ____

Please complete page 2 if you wish your child to carry and/or self administer their medication.

The student's **physician** must complete the following

Student's Last Name ______ First ______ Middle ______ Birth Date ______

Name of Medication ______ Dosage ______

I confirm that ______________________ is able to self-administer this medication.
Student's Name

Effective until: End of the School Year **OR** ______________________
Month Day Year

Printed Physician's Name ______ Physician's Licence Number ______

Physician's Address ______ Physician's Phone Number ______

Physician's Signature ______

The student's parent/guardian must complete the following

I consent to allow ______________________ to self-administer his/her medication.
Student's Name

I give permission for the PTAffiliates office personnel to consult with my child's physician if questions or concerns arise. I release the PTAffiliates and its personnel from civil liability if my child suffers adverse reaction due to the self-administration of his/her medication.

Printed Parent's Name ______ Parent's Phone Number ______

Parent's Address ______ Parent's Email Address ______

Physician's Signature ______