



PERMISSION TO CARRY AND SELF ADMINISTER MEDICATION

Date _____ School _____

Student _____ DOB _____ Room _____

Per the St. Louis Public Schools 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 parents/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, _____, 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 _____