AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Manchester High School FAX #: 860-647-3434

PHYSICIAN'S ORDER:

Student Name: _____ Date: _____

Address: _____ Date of Birth: _____

Condition for which drug is being administered: _____

Drug name, dose, method of administration & frequency: _____

_____

Relevant side effects & management of _____

Length of time during which medication shall be administered:

School year _____ or From _____ To _____
(Date) (Date)

SELF ADMINISTRATION

1. I have conferred with this child's parent(s)/guardian(s) and feel that this medication may be self-administered.

2. This student has been appropriately instructed regarding self-administration.

_____ _____
(Physician's Signature) (Date)

_____ _____
(Physician's Address) (Physician's Phone)

PERMISSION OF PARENT/GUARDIAN FOR ADMINISTRATION OF MEDICATION

To: _____ Date: _____

I hereby request that the above medication ordered by _____
(Name of Physician)

for _____ be administered by my child.
(Name of Student)

I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician.

I understand it would benefit my child for the school nurse to be supplied with back-up medication in the event the mediation is lost or misplaced.

_____ _____ _____
(Signature of Parent / Guardian) (Date) (Phone Number)