NELSON COUNTY SCHOOLS

Authorization for Self-Administration

Prescription medication must have the written permission of the child's physician and the child's parent or legal guardian. The medication must be in the original container with the pharmacy label as proof of the physician's prescription. **Signed permission will expire at the end of the school year.**

Student's Name _____ **Date of Birth** _____

This medication has been prescribed for my child by:

Primary Care Provider _____

Address _____

Phone _____

I hereby attest that this child has been properly instructed and is competent to administer the following medication:

Name of Medicine_____

Dosage _____

Time of day for dose _____

Reason medication is to be given _____

_____

Signature of Primary Care Provider _____ **Date**_____

I give permission for myself/my child to receive the above medication at school and waive any liability on behalf of the school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication. My signature will give permission for exchange of verbal and written communication between the physician and the school nurse/health staff regarding my child's medical regime.

Signature of Parent or Legal Guardian _____**Date** _____

Home phone _____

Work phone _____

Cell phone _____

Emergency contact name _____

Phone number _____

Relationship _____