

I understand that in the event that the school representative is not available, my child may have the responsibility to carry/self administer his/her medications.

My son/daughter needs the following scheduled prescribed medications:

Medication: _____ Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____
Dose: _____ Time: _____

My son/daughter may need the following “As-Needed” medications:

Medication: _____ Dose: _____ Time: _____
Give when these signs/symptoms are present: _____

Medication: _____ Dose: _____ Time: _____
Give when these signs/symptoms are present: _____

Medication: _____ Dose: _____ Time: _____
Give when these signs/symptoms are present: _____

My son/daughter may need the following EMERGENCY medications:

Medication: _____ Dose: _____ Time: _____
Give when these signs/symptoms are present: _____

____ **I understand** that each medication must be in an original clearly labeled container with student’s name. Prescription medication must be in its original prescription container. Your pharmacist will provide an additional labeled container.

____ **I understand** that these medications will be administered by non- licensed school department personnel.

____ **I give permission** for my child to carry & self-administer in the event that the school representative is not present (stays in family homes...)

Parent/guardian signature: _____ **Date:** _____