WRITTEN STATEMENT FOR SELF-ADMINISTRATION OF MEDICATION FOR POTENTIALLY LIFE-THREATENING CONDITIONS

School_____ Grade_____

STUDENT INFORMATION

Name_____ Date of Birth _____

Age_____ Weight_____

Allergies_____ or Other conditions_____

MEDICATION INFORMATION (To be completed by physician or practitioner)
Note: All medication MUST be in its original pharmacy container.
Name of
Medication_____

Expiration date_____ Start date_____ End date_____

Dosage_____ Time(s) to be taken at school_____

How medication is to be taken (circle)
oral inhaled to skin to eyes to ears other_____

Diagnosis/Health concern_____

Side Effects_____

Other medications currently taken by student_____

Comments/Additional information_____

_____ _____
Physician/Practitioner signature Date

By Signing Below:
1. I am requesting that the medication listed above be taken by my child as directed above. I understand that it is my child's responsibility to report each instance of self-administration to a teacher, principal, or nurse.
2. I acknowledge having read and understood W.S. 21-4-310 (provided).
3. I acknowledge having read and understood the District policy (JLCD) regarding self-administration of medication at schools.

Parent/guardian_____
Date_____

Emergency contact number_____

APPROVED:
School Nurse_____
Date_____

WRITTEN STATEMENT FOR SELF-ADMINISTRATION OF MEDICATION FOR POTENTIALLY LIFE-THREATENING CONDITIONS

School Principal_____

Date_____
_____

First Reading: 3-9-26
Second Reading: 4-6-26