

Request For Self-Administration of Medication

Student's Name (Last, First, Middle)

Birthdate:

Today's Date:

The above named pupil has _____

(Name of Disease, Illness or Syndrome)

I am requesting that the above named student take the following medication during school hours.

Name of Medication
(Capsule)

Type of Medication (Tablet, Liquid or

Dosage

Time(s) to be given

Possible Side Affects

I certify that the above named student has been instructed in the use and self-administration of the above named medication. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

Print Physician Name

Phone Number

Physician Address

Physician Signature

Date

Parental Authorization for Self-Administration of Medication

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby Authorize the Tulsa Legacy Charter School and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent's Signature

Home Phone

Business/Cell Phone

Date

Additional Information, if any