

Form # 4

PIPER USD 203

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION
Medications prescribed by a health care provider for the treatment of
asthma and anaphylaxis only
(Grades 5 – 12 only)

Name of Student _____

School _____ Grade _____

Medication _____ Dosage _____

Date medication started _____

Conditions under which the medication is to be taken _____

Length of time medication is to be administered _____

I hereby give my permission for _____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, its employees and agents, harmless against any claims relating to the self-administration of such medication.

**My child has been instructed on self-administration of the medication,
and he/she is authorized to do so in school.**

Signature of Parent or Guardian _____

Date _____

Signature of Health Care Provider _____

Date _____