Pekin Public Schools District 108

Physician Request for Self-Administration of Medication at School

_____ _____ _____
Name of Student Birthdate School

The above named student has _____
(Name of Disease or Syndrome)

I am requesting that the above named student be allowed to self-administer the following medication during school hours:

_____ _____
Name of Medication Type of Medication (tablet, liquid, capsule, inhaler)

_____ _____
Dose Time to be taken at school

Possible Side Effects_____

I certify that _____has been instructed in the use and self-administration of the above medication. He/She understand 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.

_____ _____
Name of Physician (PRINTED) Signature of Physician

_____ _____-_____-_____ _____
Physician Address Physician Phone # Date

Student Agreement

I, _____, agree that the above named medication is for my use only and may not
(Student's Name)
be shared with any other student at any time for any reason. I agree to report any unusual side effects to school personnel immediately. I agree that if I am found to be using this medication in excess of recommended amounts or not using it properly, I may forfeit my right to self-administer this medication. Any and all concerns about self-administration of the above medication will be discussed with the school nurse of physician immediately.

_____ _____
Student Signature Date

Parent Agreement

As the parent/legal guardian of _____, I agree to allow my child to self-
Student's name
administer the above named medication. I have reviewed the above statements and agree that in allowing my child to self-administer medication. I waive any claims against Pekin Public School District 108 and its agents in the event of adverse reaction or misuse of the above named medication. I have discussed the use and misuse of this medication with my child and agree that he/she is responsible and mature enough to use the medication only as directed.

_____ _____
Parent/Legal Guardian Signature Date