SOUTH BEND COMMUNITY SCHOOL CORPORATION

Health Services

SELF-ADMINISTRATION OF MEDICATION FORM

Student Name: _____**School**: _____

Grade: _____**DOB**: _____

TO BE COMPLETED BY PROVIDER

Name: _____ has the following acute/chronic

Condition: _____ and has been instructed in the

proper use of **(Medication Name):_____.**

The condition requires emergency administration; therefore, we request that he/she be permitted to carry the medication on his/her person. He/she understands the purpose, appropriate method, and frequency of use of this medication.

PROVIDER'S NAME (PRINT): _____

PROVIDER'S SIGNATURE: _____ DATE :_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I permit my child to carry the above listed medicine ordered by his/her physician/practitioner. I understand that sharing medication with other students will result in disciplinary action.

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

TO BE COMPLETED BY STUDENT

I understand the purpose, appropriate method, and frequency of use of this medication. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

STUDENT'S SIGNATURE: _____DATE: _____

THIS FORM MUST BE COMPLETED IN ADDITION TO THE AUTHORIZATION TO ADMINISTER MEDICATION FORM ANNUALLY