

Victory Charter School

STUDENTS

3510F(1)

AUTHORIZATION FOR SELF-ADMINISTERED MEDICATION

STUDENT NAME: _____ GRADE _____ DOB _____

PARENT/GUARDIAN NAME: _____ TELEPHONE (HOME) _____

(WORK) _____

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless Victory Charter School and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

Parent/Guardian's Signature

Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

I am recommending that the above named student be allowed to self-administer the following medication.

Name and purpose of medication _____

Identification of chronic medical problem _____

Prescribed dosage to be taken _____

Length of time medication must be taken _____

Possible side effects and/or special precautions to be taken _____

Conditions under which self-medication will take place:

_____ Independently *Child must have had training and be proficient in self-administering medication.*

_____ Trainer's Name: _____ Date of training: _____

_____ Under the supervision of a staff member

Medication should be _____ Stored in the ___ Elementary classroom ___ High School Office

_____ In the possession of the student

Type or print physician's name

Physician's Signature

Date