ROXBURY SCHOOL DISTRICT | Permission for Self-Administration of Medication for Potentially Life-Threatening Illness

v.20231211

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Name of Medication _____

Dosage of Medication _____

Guidelines for Administration *(Please be specific)* _____

_____

Possible Side Effects _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

I certify _____ suffers from a potentially life-threatening illness _____
(Student's Name) *(Condition)*

and: ■ is capable of, and has been instructed in, the proper method of self-administration of the above stated medication; ■ is physically fit to attend school and is free of contagious disease; and ■ the medication must be administered during the school day or the student would not be able to attend school.

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

To be completed by the parent/guardian:

I acknowledge that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the school district, the Board, and its employees or agents against any claims arising out of the self-administration of medication by my child.

I give permission for _____ to self-administer _____ as prescribed by his/her physician.
(Student's Name) *(Medication)*

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

This permission form is effective only for the school year for which it is granted and must be renewed each school year.