PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student	Birth Date	ID Number

Address	Telephone	Zip Code

_____ has requested that my child
Name of Physician

self-administer medication during school hours. I (Mother, Father, Legal Guardian) give permission for him/her to take medication during school hours. I will bring the medication to school.

My physician will also submit a written statement that my child is capable of self-administering the medication at school.

_____
SIGNATURE OF PARENT/GUARDIAN

_____
ADDRESS

_____
CITY ZIP

_____/_____
HOME PHONE BUSINESS PHONE

_____
DATE