CODE: JLCD-A
FORM

WRITTEN STATEMENT FOR SELF-ADMINISTRATION OF MEDICATION FOR POTENTIALLY LIFE-THREATENING CONDITIONS

District_____ Grade/Teacher_____

School_____

STUDENT INFORMATION

Name_____ Birth date_____

Age_____ Weight_____

Allergies_____ or Other conditions_____

MEDICATION INFORMATION (To be completed by physician or practitioner)

Note: All medications MUST be in its original pharmacy container.

Name of Medication_____

Expiration date_____ Start date_____ End date_____

Dosage_____ Time(s) to be taken at school_____

How medication is to be taken (circle) *oral inhaled to skin to eyes to ears other*_____

Diagnosis/Health concern_____

Side Effects_____

Other medications currently taken by student_____

Comments/Additional information_____

Physician/Practitioner signature_____ Date_____

By Signing Below:

1. I am requesting that the medication listed above be taken by my child as directed above. I understand that it is my child's responsibility to report each instance of self-administration to a teacher, principal, or nurse.
2. I acknowledge having read and understood W.S. 21-4-310 (provided).
3. I acknowledge having read and understood the policy of this district regarding self-administration of medication at schools.

*Parent/guardian*_____ *Date*_____

*Emergency contact number*_____

APPROVED:

SCHOOL NURSE_____ DATE_____

SCHOOL PRINCIPAL_____ DATE_____