



\_\_\_\_\_  
Special Circumstances

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Discontinue/Re-Evaluate/  
Follow-up Date

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Prescriber's Address

\_\_\_\_\_  
Emergency Phone

- I request the above named student possess and self-administer medication(s) listed above at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree that above named student will carry only the necessary daily dosage.
- I agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record.

\_\_\_\_\_  
Parent/Guardian Signature  
(agreed to above statement)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Business Phone

\_\_\_\_\_  
Student Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Self-Administration Authorization Additional Information