JOINT SCHOOL DISTRICT NO. 2
1303 E. CENTRAL DRIVE, MERIDIAN, IDAHO PHONE (208) 855-4500

MEDICATION CONSENT FORM
Self-Administered Medication

Student's Name _____Age ____ Date of Birth _____

School _____ Grade _____ Teacher/Advisor _____

Physician/Provider: _____ Ph._____

Medical condition requiring self-administered medication: _____

Allergies: _____

Medication(s) to be SELF-ADMINISTERED:

Medication Dose Expiration Date:

1)_____

When to administer: _____

2)_____

When to administer: _____

I give my permission for my child to self-administer the above medications. I shall indemnify and hold harmless the district 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.

The school nurse has permission to contact the Physician/Provider if necessary regarding this medication(s).

_____ _____ _____

Signature of Parent/Guardian Date Daytime Phone Number

Email address: _____

ADDITIONAL MEDICATION(S) taken **AT HOME:**

Name of Medication, dose, time taken

_____

_____