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

MEDICATION CONSENT FORM
Self-Administered Over-the-Counter Medication
High School Juniors and Seniors Only

Student's Name _____Age ____ Date of Birth _____

School _____ Grade _____ Teacher/Advisor _____

Medical condition requiring self-administered medication: _____

Allergies: _____

Medication(s) to be SELF-ADMINISTERED:

Medication	Dose	Side Effects

1)_____

When to administer: _____

2)_____

When to administer: _____

Junior and Senior students (only) may carry and self administer **one day's dose** of over-the-counter (OTC) medication for routine medical conditions with written parental consent. Medication must be in **original packaging or container**. Students who fail to adhere to this procedure may be in violation of district drug policy.

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.

_____ _____ _____
Signature of Parent/Guardian Date Daytime Phone Number

Email address: _____

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

Name of Medication, dose, time taken

_____

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