CHIPPEWA VALLEY SCHOOLS

Request for Self-Administration/Self-Possession of Medication

Student Name:_____ **Date of Birth**: _____ **Grade**: _____

School: _____ **Date**: _____

Under certain conditions, school personnel may honor parent requests to allow students to self-administer, or self-possess their medication, in a manner directed by the physician, without additional direction or supervision by school staff. For medication other than inhalers, only that day's supply of medication is to be carried. **This form must be submitted to the office at the start of the school day.**

To be completed by Physician: (For Prescription Drugs Only)

I recommend that the above mentioned prescription(s) be:
(Check one) ( ) Self-Administered or ( ) Self-Possessed, to the student named above.

_____ _____
(Physician's Signature) **(Date)**

_____
Physician's Name (Print)

Physician's Telephone Number: _____

To be completed by Parent or Legal Guardian:

- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

I do hereby request and authorize my child, named above, to: (check all that apply) ( ) Self-Administer

( ) Self-Possess

The following medication(s):_____
_____

_____ _____
Signature of Parent of Legal Guardian **Parent or Legal Guardian Name (Print)**

Telephone Numbers: Daytime:_____ **Home:** _____ **Cell:**_____