Permission to Self-Carry & Self-Administer Rescue Medication **School Year: 2025-2026**

Student: _____ **Birthdate:** _____

Grade: _____ **Teacher:** _____

The above-named student has permission to possess and to self-administer, as needed, the following medication(s) during school hours:

Medication(s) _____

Amount/Frequency _____

Reason and Comments _____

_____

Have you thoroughly discussed the self-administration procedure and dosage? ☐ YES ☐ NO

Have you advised your child **NOT** to share medication with anyone else? ☐ YES ☐ NO

Where is the medication going to be located? _____

Has the teacher been notified of the medication location? ☐ YES ☐ NO

Parent/Guardian Signature:

_____

Office use only

Student has demonstrated proficiency to self-medicate to appropriate staff. _____YES____NO

Nurse Signature:_____

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Grade: _____ **Teacher:** _____

The above-named student has permission to possess and to self-administer, as needed, the following medication(s) during school hours:

Medication(s) _____

Amount/Frequency _____

Reason and Comments _____

Have you thoroughly discussed the self-administration procedure and dosage? ☐ YES ☐ NO

Have you advised your child **NOT** to share medication with anyone else? ☐ YES ☐ NO

Where is the medication going to be located? _____

Has the teacher been notified of the medication location? ☐ YES ☐ NO

Parent/Guardian Signature:_____

Office use only

Student has demonstrated proficiency to self-medicate to appropriate staff. _____YES____NO

Nurse Signature:_____