REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Please complete this form if your child needs to administer any medication during school including, but not limited to, inhalers, epi pens, cough medicine, ibuprofen, itch cream, cough drops, and any other medications. All medications must be turned in to the front office, along with this form, before any medications can be self-administered by your child during school hours.

Student Name:_____ Date of Birth:_____

My child has (syndrome or disease) _____

I am requesting that my child self-administer the following medication during school hours:

Name of Medication:_____

Dosage:_____ Times to be Given:_____

Possible Side Effects:_____

Additional Information:_____

Name of Physician:_____ Phone Number of Physician:_____

PARENTAL AUTHORIZATION:

I certify that my child has been instructed in the use and self-administration of the above mentioned medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. In the event of a medical emergency or a reaction to the medication, I can be reached at the phone number listed below. I hereby authorize the staff at Rosemont Elementary School District 78 to allow my child to self-administer the above medication. I waive any claims I might have against Rosemont School District 78, its employees and agents, arising out of the administration of the above mentioned medication. In addition, I agree to hold harmless and indemnify Rosemont School District 78, its employees and agents, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from the self-administration of the above mentioned medication.

Parent Name:_____ Phone Number:_____

Parent Signature:_____ Date:_____