



PERMISSION FOR MEDICATION SELF ADMINISTRATION OUTSIDE OF SCHOOL HOURS ON SCHOOL GROUNDS OR AT SCHOOL ACTIVITIES

POLICY JGCD-E (3)

Student Name _____ Date of Birth _____

School _____ Grade _____

Medication _____ Dosage _____

Purpose of Medication _____

Possible Side Effects _____

Time (s) medication is expected to be taken during the school day:

Dates medication may be self-administered: From _____ to _____

Physician's Signature REQUIRED

Physician

Address

Phone

I hereby give my permission for _____ (student's name) to keep the above medication with him/her outside of school hours on the school grounds or at school activities and to administer it to himself/herself as prescribed. I understand that this medication is to be kept in its properly labeled original container. My child understands the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. My child also understands that this medication is not to be distributed to any other student or district employee. I hereby release the School District of Pickens County from any and all liability associated with the self-administration of the above medication.

Print Name of Parent/Guardian

Signature of Parent/Guardian

Date

Approved: Principal or Designee

Date