PITMAN PUBLIC SCHOOLS

SELF-MEDICATION PERMISSON FORM

Students with asthma or other potentially life-threatening illnesses may carry their inhalers or other medication with them. The pupil's doctor must certify the diagnosis and that the student is capable of self-administration.

Name of Student____

Date of Birth_________________________School___________________________Grade_______

TO BE COMPLETED BY PHYSICIAN:

Diagnosis___________________________Name of Medication_________________________________

Specific time(s) and dose(s) to be taken____

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Length of Time____

Has the student received instruction and capable of performing the appropriate method of self-administration? ______Yes _____No

Comments/Nursing Implications:____

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____________________________________ ____________________________________

Printed Name of Physician/Phone Number Signature of Physician

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TO BE COMPLETED BY PARENT:

I, _______________________________________, give permission for my child,

____, to self-administer the above medication as directed. Pitman School District and its employees and /or agents shall not be liable for any injury resulting from the self-medication.

____________________________________ ____________________________________

Date Parent/Guardian Signature

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Telephone Number