Riley County Schools-USD 378

Permission for Self-Administration of Anaphylaxis or Asthma Medication

Name of Student_____

School_____ Grade_____

Teacher_____

Medication_____Doseage_____

Date Started_____

Conditions under which the medication is to be given:

_____

Any additional circumstances under which the medication is to be given:

_____

Length of time medication is to be administered:

_____

I hereby give my permission for _____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employeeds and agents, harmless against any claims relating to the self-administration of such medication.

My child has been instructed on self-administration of the medication and is authorized to do so in school.

Signature of Parent or Guardian:

_____ Date_____

Signature of Health Care Provider:

_____ Date_____