L'Anse Area Schools
Permission to Self-Administer/Carry Over–The-Counter Medication

Student: _____ **Date of Birth:** _____
Last name First MI

Grade: _____ **Home Teacher:** _____

Section I: To be completed by parent/guardian.

1. Name of medication: _____

2. Reason for medication: (optional) _____

3. Form of medication/treatment: ___ Tablet/capsule ___ Liquid ___ Other: _____

4. Instructions (Schedule and dose to be taken while student is in school): _____
   _____
   Start: _____ date form received **OR** Other dates: _____
   Stop: _____ end of school year **OR** Other date/duration: _____
   ___ For episodic/ emergency use only.

5. Restrictions and/or important side effects: ____ None anticipated _____ Yes, please specify/describe: _____
   _____

6. Special storage requirements: ___ Refrigerate ____ None ___ Other _____

7. This student is both capable and responsible for self-administering this medication:
   ___ Yes-Supervised ___ Yes-Unsupervised

8. This student may carry this medication: ___ Yes

9. Please indicate if you have provided additional information: _____
   _____

Section II: To be completed by the parent/guardian and returned to school:

I request that (name of student) _____ be allowed to self-administer the above medication at school according to the school policy.

Signature: _____ **Relationship:** _____ **Date:** _____

Section III: To be completed by the student.

I understand that I will follow the medication policy guidelines. If I am permitted to carry and self-administer my medication, **I will not give my medication to another student.**

Signature: _____ **Date:** _____ **Updated: 05/2682016**