

HIGH POINT REGIONAL HIGH SCHOOL
Health Office
Parental Permission for Student to Self-Administer Medication
School Year 2016-17

Student's Name: _____ Grade: _____

Illness for which medication is prescribed: _____

Name of Medication(s): _____

When and how should medication be taken? _____

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- As per State law, I hereby grant permission for the above-named student to carry and self-administer the medication(s) listed above.
 - I will instruct my child to notify the school nurse, a teacher, coach or other employee whenever the medication is self-administered.
 - I understand that the school district shall incur no liability as a result of any injury arising from the self-medication, and I hold the district harmless against any injury or claims that arise as a result of self-medication.
 - I understand that this permission is effective for this school year only and must be renewed annually.
 - I will obtain written certification from my child's physician regarding self-medication. (see attached form)

This form is for "potentially life-threatening illnesses" only, such as asthma, bee sting allergies, anaphylaxis, diabetes and cystic fibrosis. No other medications are to be carried and self-administered by student.

Permission for the school nurse to administer *any* medications requires a separate note from a parent or guardian.

Parent/Guardian Signature	Printed Name	Date
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Principal's Signature	Date
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School Nurse Signature	Date
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