

HIGH POINT REGIONAL HIGH SCHOOL  
Health Office

**Parental** Permission for Student to Self-Administer Medication  
School Year 2010-2011

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

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

HIGH POINT REGIONAL HIGH SCHOOL

Health Office

**Physician's Certification for Student  
To Self-Administer Medication  
For school year 2010-2011**



Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis/reason medication is prescribed: \_\_\_\_\_

Name of Medication(s): \_\_\_\_\_

Dosage: \_\_\_\_\_

Method of Administration: \_\_\_\_\_

When medication should be taken: \_\_\_\_\_

I certify that the above named student is capable of and has been instructed in the proper administration of the specified medication. Please allow this student to carry and self-administer the medication at school.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # \_\_\_\_\_

*\*\* Please note: This form is for "potentially life-threatening illnesses" only, such as bee sting allergy, asthma, diabetes, and cystic fibrosis. No other medications are permitted to be carried and self administered by students.*

Reviewed by: Principal \_\_\_\_\_

School Physician \_\_\_\_\_

School Nurse \_\_\_\_\_