WALLINGFORD SWARTHMORE
SCHOOL DISTRICT

PARENT/DOCTOR AUTHORIZATION TO CARRY OWN MEDICATION

Date ______________

_________________________ has been instructed in the proper use of _______________________
(Student Name) (Name of Medication)

We, ______________________________ and ____________________________, request that
(Physician) (Parents/Guardians)

he/she be permitted to carry the medication on his/her person, as we consider him/her responsible. He/She has been instructed and understands the purpose and appropriate method and frequency for use of this medication. Student is also aware that the medication is intended for his/her use only and not to be shared with others. Violation of this policy shall result in immediate confiscation of the medication and loss of this privilege. **We hereby relieve the school and its employees of any responsibility for the benefits or consequences of the medication and acknowledge that the school bears no responsibility for ensuring that the medication is taken.**

Please note: All students must report to nurse, if there is no resolution of symptoms.

Please complete the following information:

Diagnosis: ____

Name of Medication: ____________________________________ Dose: ______________

If Medication is to be taken **DAILY**, at what time? _____________________________________

If Medication is to be taken **WHEN NEEDED**, describe indications: ____________________

____

How soon can it be repeated? ____

Is student authorized to self-medicate? _____YES _____NO

List significant side effects: ____

Date to stop medication: ______________

Emergency response protocol:

1. ____

2. ____

3. ____

_______________________________ (Physician signature)

_______________________________ (Parent/Guardian signature)

_______________________________ (Physician phone number)

_______________________________ (Parent/Guardian phone number)