



**MEDICAL RELEASE FORM
Self-Administration**

_____ has been instructed in the use of _____
(Students Name) Medication

We, _____ and _____
(Physician) (Parent/Guardian)

request that this student be permitted to self-administer this prescription medication and to carry it on his/her person or to keep it in his/her locker or P.E. locker, because we consider him/her responsible for its administration. We authorize him/her to do so. He/she has been instructed in and understands the purpose and appropriate method, frequency, dosage, and use of his/her medication.

We, the undersigned, release the District and its employees of any and all liability resulting from this student's possession and self-administration of his/her medication. We acknowledge that, from this day forward, the District assumes no supervisory responsibility over the student's self-administration of the above-listed medication(s).

Physician Signature Date

Parent/Guardian Signature Date

School Nurse Signature Date

Principal Signature Date

NOTE: This form must be completed in addition to the routine Medication Authorization form for those students who request permission to carry their own medication on campus.