

CHEATHAM COUNTY SCHOOL DISTRICT
HEALTH SERVICES

Authorization to assist competent students with self-administration of
prescription and over-the-counter medications

Student's Name	School	Grade	Date of Birth
----------------	--------	-------	---------------

Physician's Name	Physician's address	Phone	Fax
------------------	---------------------	-------	-----

Name of medication: _____

Time(s) medication is to be taken: _____

Amount of medication to be taken: _____

How medication is to be taken (orally, topically, inhalation, etc.): _____

How soon can medication be repeated: _____

Reason medication is needed at school: _____

Date the last dose of the medication is to be taken: _____

List significant side effects of this medicine: _____

Physician's Signature: _____ Date: _____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Cheatham County School District, the undersigned parent/guardian hereby agrees to release Cheatham County School District and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication. I hereby give my permission for _____ to take the above medication as ordered. My child is competent to self-administer this medication with assistance. I understand that it is my responsibility to furnish, to deliver, and to pick-up this medication when completed. I understand that my child will be self-administering this medication with the assistance of appropriate school personnel.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name Printed: _____

Phone: _____ Work phone: _____ Emergency phone _____