STERLING HIGH SCHOOL

Home of the Silver Knights

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PARENT/GUARDIAN AUTHORIZATION FOR
SELF-ADMINISTRATION OF MEDICATION BY STUDENT

STUDENT NAME: ____ D/O/B: _________________________

NATURE OF ILLNESS/CONDITION: ____

TYPE OF MEDICATION: ____

We, the undersigned, are the parents/guardians of the student named above.

We have been advised by you that legislation has been enacted allowing parents or guardians of a student who has asthma or another potentially life-threatening illness to authorize self-administration of medication by the student so long as the student's physician certifies to you that the student is capable of, and has been instructed in, the proper method of self-administration of medication.

We have also been advised by you that if we do give this authorization, the school district and its employees and agents will incur no liability as a result of injuries arising from self-administration of medication by the student. We agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the self-administration of medication by the student.

The student named above suffers from the illness or condition identified and is required to take the stated medication. We authorize the student named above to administer this medication to him/herself while the pupil is under your jurisdiction.

NOTE: MEDICATIONS BROUGHT TO SCHOOL MUST BE PRESCRIPTION LABELED

I/We understand that this authorization only applies to this current school year. I/We have the right to choose to sign and submit a new Parent/Guardian Authorization for Self-Administration of Medication by a Student form for each future school year.

____ ________________________________
SIGNATURE OF PARENT/GUARDIAN * DATE

____ ________________________________
SIGNATURE OF PARENT/GUARDIAN * DATE

* In any case involving two parents or more than one guardian, all parents & guardians must sign the written authorization.