Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

PARENT AUTHORIZATION FOR STUDENT TO SELF-MEDICATE

(Registered Nurse must meet with student to review responsibilities)

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

As the parent/guardians of the student named above, we/I authorize her/him to take (self-administered) the following medication at school:

Name of medication : _____

Amount/dosage : _____

Time student will take medication : _____

Date medication will start : _____ To end: _____

Physician's Name : _____ Phone: _____

Health problem requiring medication: _____

Possible reactions/side effects: _____

Where will the medication be kept at school? _____

It is understood that school personnel will not be responsible or liable for the administration of the medication listed above. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication. We/I are aware the privilege of self-administration of medication can be withdrawn if abused by the student.

_____	_____	_____
Parent / Guardian Signature	**Home Phone**	**Work Phone**
_____	_____	_____
Parent / Guardian Signature	**Home Phone**	**Work Phone**

Distribution: **Nurse**
(Rev 8-2017)