



## Sheffield-Sheffield Lake City Schools

### Request that Student Carry & Administer Own Medication

Student Name	School	Class
Address		Date of Birth

### To be Completed by Physician

The above student is under my care and should be allowed to carry and administer his or her personal medication.

Name of Medication

Dosage and times or intervals of administration

The student has been instructed and demonstrates knowledge of the proper circumstances in which this medication should be administered, as well as the proper care, storage and administration of the above indicated medication.

Start Date:	Stop Date:
-------------	------------

Possible Side Effects or severe adverse reactions to watch for:

Physician's Signature

Date

Physicians Name

Phone

Address

### To be Completed by Parents/ Guardians

I hereby make request and give my permission for my child to administer his/her own medication, therefore in keeping with the above section. Further, I hereby release from liability, and in addition agree to indemnify, all school employees and the Board of Education for damages or injury resulting from the use, misuse, or nonuse of such medication except as such Board or its employees are grossly negligent or engage in wanton or reckless misconduct. I further agree to submit a revised statement signed by the physician who has prescribe the medication in the above section in the event that I become aware that nay of the information set forth in that Section has changed. I have read and understand the policy of the Sheffield-Sheffield Lake City Schools for the administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication at school by school personnel.

I understand that my child may be subject to discipline for misuses of the medication at school.

Parent Signature	Date
------------------	------

**This form will expire at the end of the current school year**