**AUTHORIZATION TO SELF-CARRY AND SELF-ADMINISTER NON-PRESCRIPTION PAIN RELIEF MEDICATION**

***Please Print:***

Student ______________________________ Date of birth ______________

Parent/Guardian ______________________________

School ______________________________ Grade ________

Name of Medication ______________________________

Dosage ______________________________
(in a manner consistent with the labeling)

Allergies ______________________________

Reason for Use ______________________________

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***Parent Responsibilities:***

- I have instructed my child on the use and administration of this medication
- I will send the medication in its original bottle/container
- I release school personnel from liability in the event that any reaction results from the administration of this medication.

______________________________ ______________
Signature of Parent/Guardian Date

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***Student Responsibilities:***

I know how to use and administer this medication correctly:

- proper dosage – how much to take
- proper timing – how often to take
- proper storage – kept in its original bottle/container in a safe, secure place
- proper user – not to be shared with others

I, ______________________________, agree to the above responsibilities.
*(Student name)*

I understand this is a privilege which may be revoked if the school district determines that I am abusing the privilege.

______________________________ ______________
Signature of Student Date

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______________ Date received ______________ Date reviewed by School Health Office