

**Santa Fe Trail
USD 434**

**Permission for Self-Administration of Medication
(Asthma Inhalers or Epi-Pens Only)**

Name of Student _____

School _____ Grade _____

Teacher _____ Physician _____

Medication _____ Dosage _____

Diagnosis _____ Date Started _____

Conditions under which the medication is to be given:

Any additional circumstances under which the medication is to be given:

Length of time medication is to be administered:

I hereby give my permission for _____ to administer the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

**My child has been instructed on self-administration of the
medication and is authorized to do so in school.**

Signature of Parent or Guardian

[NOTE: Parental permission must be renewed annually]

_____ Date _____

Signature of Health Care Provider

_____ Date _____

Approved: 8/05

