Maggie L. Walker Governor's School Medication Administration Permission:

Permission for Student Administration of Medications

To be completed by the parents:

Student's Name _____

Date of Birth _____

Grade _____

Please permit _____ to carry and self-administer medication.

Parent's signature _____

Print name _____

Telephone number _____ Date _____

List medication(s): _____

_____

To be completed by physician:

_____ is under physician recommendation to self-medicate at the dosage stated below. In my opinion he/she is able to self-administer this medication and has a full understanding of side effects and consequences of improper administration of this medication. It is my recommendation that this student be allowed to have this medication on their person.

Physician's signature _____

Print name _____

Phone number _____ Date _____

Medication name(s) and dosage: