Community Health Network

Request for Student to Possess and Self Administer Medication
2024-2025

A student may possess and self-administer medication for a chronic disease or medical condition ONLY if the parent or guardian annually files with the clinic this form signed by the parent or guardian and ***BY A PHYSICIAN***. This form will be valid for one school year only, and a new form filled out each school year.

Parent or Guardian Authorization

I am the Parent / Guardian (circle one) of the student identified below. I authorize school to permit this student to possess and self-administer the medication identified below on school property and during school time.

_____ _____
Student's Name (Please print) Name of medication

_____
Purpose of medication

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name Phone Number

Physician's Statement

I am a licensed physician. I provide medical services to _____
(name of student) and have prescribed _____*(name of medication)*
for this patient. I certify that the following statements are true and accurate:

A. An acute or chronic medical condition exists for which the above named medication is prescribed
B. The student named above has been given instructions as to how to self-administer the medication; and
C. The nature of the disease or medical condition requires emergency administration of the medication

_____ _____
Physician's Signature Date

_____ _____
Physician's Name Printed Phone Number

_____
Physician's Address

Student's Statement

I agree to use the above medication in accordance with school policies. I will not share this medication with any other students, I will keep it on my person at all times, and I will not use it for any other purpose than stated by my physician.

_____ _____
Student's name Date