Covington ISD

# AUTHORIZATION FOR STUDENT SELF-MEDICATION

The following section is to be completed by the parent/guardian:

_____ ____/____/____ _____

Student Name Date of Birth School

Physician Name: _____ Physician Telephone: _____

**I request that my child be permitted to self –medicate her/himself as authorized by me and their physician.**

Parent/Guardian Signature: _____ Date:_____

Parent Telephone: _____

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The following section is to be completed by the physician:

Diagnosis: _____

Medication Name: _____ Dose:_____ Route:_____

Time of Medication Administration: _____

If PRN, describe indications: _____

How soon can it be repeated? _____

Is student allowed to carry medication on his/her person? _____

List significant side effects: _____

Length of time this treatment is recommended?

_____

Other Information: _____

_____

_____

Physician Signature:_____ Date:_____