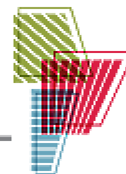
THE JOHN **CROSLAND** SCHOOL 

SELF-MEDICATING STUDENT/PARENT/PHYSICIAN AGREEMENT

PHYSICIAN AGREEMENT:

I have provided education to ____
Student's Name
and given the authorization for self-administration of ____________________________
Medication
during school hours and activities.

Physician's Signature: ______________________________________ Date: _________

PARENT AGREEMENT:

I, ________________________________, agree that my child, _____________________
Parent/Guardian Name Student's Name
Is knowledgeable of his/her treatment and is capable of self-administering the above named medication. I absolve The John Crosland School and their agents and employees from any and all liability whatsoever that may result from my child's possession and self-administration of the above named medication.

Parent/Guardian Signature: ___________________________________Date: _________

STUDENT AGREEMENT:

I agree and feel capable to take my own medication as prescribed. I will not at any time share my medication with another student and I will keep it secure from other students.

If I have any problems self-administering my medication or any health problems arise, I will seek assistance from school personnel so not to jeopardize the health or the safety of myself or my fellow students.

Student's Signature: ______________________________________ Date: __________

Printed Name: ______________________________________ Birth Date: __________