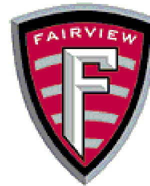
Self Administration of Medication Form



Fairview Park City Schools
21620 Mastick Rd. # A
Fairview Park , OH, 44126
Phone: 440.331.5500
Fax: 440.356.3545
www.fairviewparkschools.org

Student Name:

Grade:

Date of Birth:

Address:

State:

Zip/Postal Code:

Phone Number:

PART I: MUST BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Medication:

Physician's Name:

In accordance with the Fairview Park Board of Education policy regarding medicine in the schools, I am requesting permission for my child to carry, use or take the above medication. This is per my direction as ordered by my physician and will be taken during the school day and/or while on school property. I understand that my child is to have only the quantity of medication necessary for use during a single school day. I am aware that no student may give, distribute or make available to other students any prescription, non-prescription/over-the-counter medications.

Date:

Phone:

Signature of Parent/Gaurdian

PART II: MUST BE COMPLETED BY A PHYSICIAN

Student Name: Student Grade:

Medication:

Date to begin medication: Date to end medication:

Time to take medication:

Possible adverse reactions to this medication to watch for:

Date:

Phone:

Signature of Physician