FORM 7020.1

NOTIFICATION OF STUDENT SELF-MEDICATION

Student:	D.O.B.:	
Teacher:	Grade:	Room:

PARENTAL REQUEST

As the parent/guardian of _____, I am notifying the school that my son/daughter will be self-administering the medication prescribed by my child's physician at the prescribed time.

I agree to send my child to school with the necessary daily supply prescribed. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

Signature of Parent/Guardian	Date
Address	
Phone #	

PHYSICIAN'S STATEMENT

In order to protect the health of _____

It is necessary for her/him to have the following medication during school hours.

Medication:	
Dosage:	
Time to be administered:	
Purpose of medication:	
List any possible side effects that might be expected:	
Diagnosis:	

I authorize _____ to self- administer the above medication.

Signature of Physician	Date
Print Physician Name	Phone