HIGH POINT REGIONAL HIGH SCHOOL
Health Office
Parental Permission for Student to SelfAdminister Medication

Student's Name:____DOB:____________________

School Year:_____________________________________ Grade:________________________________

Illness for which medication is prescribed: ____

Name of Medication(s): ____

When and how should medication be taken? ____

▪ As per State law, I hereby grant permission for the above named student to carry and self administer the medication(s) listed above.

▪ I will instruct my child to notify the school nurse, a teacher, coach or other employee whenever the medication is self administered.

▪ I understand that the school district shall incur no liability as a result of any injury arising from the self medication, and I hold the district harmless against any injury or claims that arise as a result of self medication.

▪ I understand that this permission is effective for this school year only and must be renewed annually.

▪ I will obtain written certification from my child's physician regarding self medication. (see attached form)

This form is for "potentially life threatening illnesses" only, such as anaphylaxis, asthma, anaphylaxis, diabetes, and cystic fibrosis. No other medications are to be carried and self administered by the student.

Permission for the school nurse to administer *any* medications requires a separate note from a parent or guardian.

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Parent/Guardian Printed Name Signature Date

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School Nurse Signature Date

Updated 6/2021