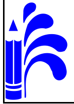

FHUSD #98
Student Self-Administration of Medication or Treatment

Recommendation for Student Self-Administration of Medication or Treatment

(Not for use for controlled substances, under regulation of the Controlled Substance Act of 1970)

Note: Physician signature not required for inhalers and Epi-pen.

Date: __________

Student: ____

Medication: ____

Dosage, Route and Time or Frequency: ____________________________

Reason for Medication: ____

Allergies: ____

The above named student is to be allowed to carry and have responsibility for the above medication or treatment from________ to ________ or duration of school year 20__ - 20__.

Note: A new medication form is required for each school year.

For students who require inhalers or other emergency medications; please, write the prescription for two (2) medication containers or inhalers, so that a back-up can be kept in Health Office, if possible.

Physician Name: ____

Physician Address: ____

____

Physician Phone: (_____) ______-__________ (_____) ______-_________
Fax phone #

____
Physician Signature (not required for rescue inhalers or epi-pens)

_________________________ (______)______-________
Parent or guardian name Home phone#

_________________________ (______)______-________
Parent or guardian signature Cellular phone #

(______) ______-________ (Ext.____)
Work phone

(FHUSD Form MA-3)(revised 2011)