Marion Cross School

22 Church Street, Norwich, VT 05055
Phone: 8002-649-1703
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Shawn Gonyaw
Principal

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL

Name of Student:		**Grade:**
Date of Birth:	Address:	
Condition for which the medication is administered:		
Name of Medication:		Dose & method:
Time for administration:		
Duration (limit to 1 school yr)	Start date:	End date:

In my opinion, this student shows capability to carry and self-administer the above medication.

Physician Signature **Date**

Physician Printed Name **Physician Phone Number**

Parent/Guardian Authorization

I request that _____, be permitted to : _____ carry/____self-administer (check one or both), the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, including the original label indicating the student's name, prescribing health care provider, medication name, date of original prescription, strength and dose of prescription, and directions for use.

Parent/Guardian Signature **Date**

Parent/Guardian Printed Name