Xavier Charter School
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Twin Falls, Idaho 83301
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AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

PHYSICIAN SECTION

_____ _____ _____
Name of Student | Birth Date | School Year

The above named student has _____
Name of Disease, Syndrome, and Condition for which this medication is needed.
I am requesting the above named student may carry on their person, and self-administer the following medication during school hour's and extracurricular school activities.

MEDICATION

_____ _____
Name of Medication | Type of medication

_____ _____
Dosage | Time(s) to be administered

_____
Possible side effects

I certify that the above named student has been instructed in the use and self-administration of the above medication(s).

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____
Print Name of Physician / Care Provider | Signature of Physician / Care Provider

_____ _____
Telephone Number of Physician/Care Provider | Fax Number of Physician/Care Provider

PARENT/GUARDIAN SECTION

I give my permission for my child to self-administer the medication described above. I give my permission to the school to call 911 in the event that my child does not have his/her medication and an emergency situation does arise. I shall indemnify and hold harmless Xavier Charter School and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above name student/child or anyone else.

_____
Print Name

_____ _____
Parent/Guardian Signature | Date