



**After School Hours/Out of District/Away Events
Self-Administration Medication Form
Secondary Students**

Date: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SCHOOL: _____

PARENT'S NAME: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

DOCTOR'S NAME: _____ OFFICE PHONE: _____

NAME OF MEDICATION: _____

STRENGTH OF MEDICATION: _____

DOSE: _____ EVERY _____ HOURS
(number of tabs) *(number of hours)*

TIME TO BE ADMINISTERED:

SPECIFIC TIME _____

AS NEEDED

REASON FOR MEDICATION ADMINISTRATION: _____

I hereby authorize my child to self-administer the above medication. I have reviewed the Rockford Public Schools policy and realize any variation will be a violation of the Rockford Public Schools Medication Policy.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Expires one (1) year from approval date.