



VESTAL NEW YORK 13850

# SELF-MEDICATION RELEASE FORM

*It is anticipated that the need for immediate availability of medication would be rare. ALL medication should be used for potentially severe, acute medical problems only.*

**Date** \_\_\_\_\_

**Child's Name** \_\_\_\_\_

*has been instructed in the proper use of the following medication procedures:*

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*We* (Physician's signature) \_\_\_\_\_

*and* (Parent or Guardian's signature) \_\_\_\_\_

*request that* (Child's name) \_\_\_\_\_

*be permitted to carry the medication on his/her person as we consider him/her a responsible person. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.*

- ◆ **Note:** This form must be completed *in addition* to the routine district medication form for those students who request permission to carry their own medications.