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)