SPENCERPORT CENTRAL SCHOOL DISTRICT

SELF-MEDICATION ATTESTATION AND PARENT PERMISSION

7513F.2

Student's Name_____

Date of Birth:_____ Today's Date: _____

I attest that the above named student carries the diagnosis listed below and has been instructed in and demonstrated skill in the proper dose, use, and storage of the following life-saving and/or essential medical procedures for the stated diagnosis as checked:

□ Epinephrine Auto-Injector for life-threatening anaphylaxis: Dose and Indications

_____

□ Asthma inhaler for asthma: Dose and Indications

_____

□ Essential testing materials, medication supply, and rescue medication for diabetes: Dose, Frequency, Indications:

_____

□ Other life-saving medication indicated below with dose, frequency, and indications:

_____

(Prescriber's signature and title) _____
Stamp:

I give permission and request that my son/daughter be allowed to carry on his/her person and/or store the above medication as prescribed by our prescriber in his/her locker or bag. I have educated my son/daughter in the proper use and safe and secure storage of the same. I understand that if my son/daughter is found to pose a risk of danger to self or others, the school may confiscate it, require assistance by health office staff, and store in the health office until resolution with my prescriber.

(Parent or Guardian's signature) _____