Campbell County School District #1

Request for Student
Self-Administration of Allergy Medications

Student Name:	**Date of Birth:**

TO BE COMPLETED BY PHYSICIAN

Diagnosis _____

Medication (dosage, frequency, route) _____

Adverse reactions/Side effects _____
_____

List other medications currently being taken _____

Student is capable of self-administration of his/her allergy medication(s) and should be allowed to carry it for this purpose: ☐ YES ☐ NO

Name of Prescribing Physician_____
Address _____ Phone _____

Physician's Signature _____ Date _____

My child has been instructed in the proper use of the above allergy medication(s). I certify that my child is capable of carrying and self administration of medication(s). I request that he/she be permitted to carry and self-administer the above allergy medication(s). I authorize the release of information between the school and physician pertinent to my child's medication(s) and allergy diagnosis.

My child and I understand that there are serious consequences for sharing any medications with others. Furthermore, I understand that the school shall incur no liability, and I will hold the school and its employees harmless against any claims relating to self-administration of allergy medication(s).

_____ _____
Parent/Guardian Name (print) Relationship to Student

_____ _____
Parent/Guardian Signature Date

*This form is good for one school year only and needs to be resubmitted each year.