SELF ADMINISTRATION OF STUDENT MEDICATION AUTHORIZATION

	I,, as the parent or legal guardian of					
	(student's name) hereby authorize my child to					
posses	s and self-adminis	ter emergency medicat	tion at school, on	school ground	ls, at school	
sponso	ored activities, on s	school transportation, a	and during school	l-related progra	ams.	
	My shild has has	n diagnosad with			(nomo	
of space	ific life threatening	n diagnosed with	and is canable o	of and has been	(name	
	specific life-threatening allergies or asthma), and is capable of, and has been instructed					
	(name of physician) in the proper self- ministration of the emergency medication indicated for the treatment of his/her allergies or					
asthma		ergency medication in	neated for the tre	atment of ms/	ner anergies or	
	•	ave been advised by his	- ·	-		
_	•	nd have been informed			•	
	•	ld understands, that in		self-administe	rs their emergency	
medica	ation, they must no	otify a school employed	e immediately.			
	The attached plan	n of action developed f	or the	scł	nool year in	
consul		nool nurse, is based upo				
physic	ian and includes th	he name of each emerg	ency medication,	, the dosage, ar	nd the times and	
circum	nstances under whi	ich the medication is to	be used. The plant	an also include	es the names of the	
individ	duals who will be a	given copies of the plan	n and indicates th	at the medicat	ion provided is	
solely	for the use of my	child.				
	I hereby release (Colchester School Dist	rict, its employee	es, agents, volu	inteers and its	
board 1	members, from lia	bility as a result of any	injury arising fro	om my child's	self-	
admini	istration of emerge	ency medication, excep	ot when the condu	act of the school	ol, school	
employ	yee, or agent woul	d constitute gross negl	igence, recklessn	ess or intentio	nal misconduct.	
	Signed on this	day of	, 20	_ at	, Vermont	
by:						
	Parent or Legal C	Guardian's Signature				
	Witnessed by:					
	•					

PHYSICIAN'S STATEMENT SELF ADMINISTRATION OF EMERGENCY MEDICATION

	(student's name) has one or more life-
threatening allergies or asthma or both:	
threatening allergies or asthma) and has been	prescribed the following emergency medication(s):
1.	
Name of Medication	Dosage Prescribed
Times and circumstances under which the med	dication is to be taken:
Times and encomplances under when the med	diediton is to be taken.
2. Name of Medication	
Name of Medication	Dosage Prescribed
Times and circumstances under which the med	dication is to be taken:
3. Name of Medication	Dosage Prescribed
	_
Times and circumstances under which the med	dication is to be taken:
PHYSICIAN'	S AFFIRMATION
- 1	
	(student's name) is capable
	nod of self-administration of this medication. The effects of the medication and informed of when and
how to access emergency services if needed.	arects of the medication and informed of when and
<i>y</i> ,	
DI CONTRACTOR OF THE CONTRACTO	D .
Physician's Signature:	Date:
Physician's Name:	