MURRAY SCHOOL DISTRICT
5102 S. Commerce Dr.
Murray, UT 84107
(801) 264-7400

STUDENT SELF-ADMINISTRATION MEDICAL FORM

Today's Date:_____

_____ _____
Student Name Birth Date

_____ _____
Address City State Zip

EMERGENCY CONTACT INFORMATION:

Name:_____ **Phone:**_____

HEALTH CARE PROVIDER AUTHORIZATION

The above-named student is under my care. I feel it is medically appropriate for the student to self-administer medication and be in possession of medication at all times.
The medication prescribed for this student is:

Name of Medication: _____

Type of Medication (inhaler, tablet, etc.) _____

Dosage: _____

Possible Side Effects: _____

_____ _____
Signature of Health Care Provider Date

PARENT/GUARDIAN AUTHORIZATION

- ❑ I authorize my child to carry and self-administer the medications described above consistent with UCA §53A-11-602.
- ❑ I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences, which may include suspension, for sharing any medication with others.

_____ _____
Parent/Guardian Signature Date