

**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