

MOUNT SINAI UNION FREE SCHOOL DISTRICT
P.O. BOX 397, NORTH COUNTRY ROAD
MOUNT SINAI, NEW YORK 11766

SELF-MEDICATION RELEASE
FORM A

Grade Level: _____

Student's Name (Please print.): _____ has
been instructed in the proper use of the following medication procedures:

Name of medication: _____

Procedures: _____

We request that the above named student be permitted to carry the medication on his/her person. We consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Signature of Physician

Date

Signature of Parent/Guardian

Date

NOTE:

This form must be completed in addition to the *Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips* for those students who request permission to carry and administer their own medication (prescription and over-the-counter) on school trips.