JAMESVILLE-DEWITT HIGH SCHOOL

6845 EDINGER DRIVE
PO BOX 606
DEWITT, NY 13214

PAUL GASPARINI, PRINCIPAL
WILL DOWDELL, ASSISTANT PRINCIPAL
DAVID NYLEN, ASSISTANT PRINCIPAL

Medication Authorization Form

PHONE: 445-8329 FAX: 251-2304

Self -Carry/Self-Administer /Attestation Form

Student Name:_____

Date of Birth: _____ **Grade:**_____

I attest that this student has demonstrated to me that they can self-administer the medication listed below safely and effectively, and may carry and use this medication independently at any school/school sponsored activity. He/she has been instructed in and understands the purpose and appropriate method, dosage and frequency of use.

Diagnosis:_____

Medication Name:_____

Dosage: **Amount**_____

Frequency_____

Route_____

Time_____

Duration of Treatment:_____

Possible side effects/adverse reactions:_____

_____

_____

Physician Signature **Date**

_____

Physician Name (Print) **Phone Number**

_____

Parent/Guardian **Date**