Jamesville-DeWitt Central School District

Self-Carry Medication Release Form

Student Name:_____

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

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):_____

Physician Phone Number:_____

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Parent/Guardian Signature:_____ **Date:**_____

School nurse contact information is available at www.jamesvilledewitt.org.

Jamesville-DeWitt Central School District * P.O. Box 606 * DeWitt, NY 13214