



WEST ISLIP PUBLIC SCHOOLS

School Health Services

SELF-MEDICATION RELEASE FORM

Date: _____

Child's Name: _____
has been instructed in the proper use of the following medication procedures:

We, (Physician's signature) _____

and (Parent or Guardian signature) _____

request that (Child's Name) _____ be permitted to self administer his/her medication on field trips or during the absence of the school nurse. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

***NOTE:** This form must be completed **in addition** to the routine district medication form.