Livingston
PUBLIC SCHOOLS

SELF-MEDICATION LAW 1-2600

(For Asthma and Life-Threatening Conditions)

TO BE COMPLETED BY PHYSICIAN:

Student's Name: _____

School: _____ Grade: _____

Diagnosis: _____

Medication: _____

Patient is capable and has been instructed in the proper self-medication of his/her medication:

☐ Yes ☐ No

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

My son/daughter will be allowed to self-administer medication as prescribed by the doctor. The school district shall incur no liability as a result of any injury arising from self medication. The permission form is effective for one school year and must be renewed annually.

Parent/Guardian's Signature: _____ Date: _____

Phone Number: _____