St. John' s Preparatory High School
21-21 Crescent Street
Astoria, NY 11105
718 721-7200
Medical Office

SELF-MEDICATION RELEASE FORM

Date: __________________________

Student's Name: __________________________________Grade_________

My son / My daughter has been instructed in the proper use of the following medication procedures:
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____

We, (Physician's signature) ______________________________________

(Parent/Guardian's signature) _____________________________________

request that (Student's name) ____________________________________
be permitted to carry the medication as we consider the student responsible.
The child 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 prescription medication form for any student who needs to take any medication (including over-the-counter medicines) during school hours. If you have any questions contact the school nurse in the medical room. (718) 721-7200 ext.624)