

**SACRED HEART-GRIFFIN HIGH SCHOOL
REQUEST FOR SELF-ADMINISTRATION OF MEDICATION
AND RELEASE FROM LIABILITY
Academic Year: 2026–2027**

Student Name: _____

Date: _____

I request that the above-named student be permitted to self-administer the following medication during school hours:

Name of Medication: _____

Type (e.g., tablet, liquid, inhaler, etc.): _____

Possible Side Effects: _____

I certify that _____
(*Name of Student*)
has been instructed in the proper use and self-administration of

(*Name of Medication*).

He/she understands the importance of taking this medication as prescribed and will notify school personnel of any adverse side effects or reactions. The student is capable of independently managing and administering this medication.

In case of a medical emergency or adverse reaction, I can be reached at the phone number listed below.

I/we hereby release, relieve, and discharge Sacred Heart-Griffin High School and its employees from any and all liability for injury or damage to the health of the above-named student resulting from the self-administration of medication during school hours.

I/we have read, understand, and agree to the school's medication policies and procedures. I also understand that this form is valid only for the **2026–2027** academic year and must be renewed annually.

Parent/Guardian Signature: _____

Phone Number: _____

Date: _____

NOTE: All medication must be properly labeled with the student's name.