

SELF-MEDICATION RELEASE FORM

Date: _____

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

We, (Physician's signature) _____

Request that (Child's name) _____ be permitted to carry the
medication on her person or to keep same in her dorm room, as we consider her responsible. She
has been instructed in and understands the purpose and appropriate method and frequency of use.

Please return all medical forms to:
Beth Costello (Hoop Mountain Health Director)
137 Davis St.
Painted Post, NY 14870

For questions concerning medical forms please e-mail
Beth Costello at:
erc0426@yahoo.com