MARIAN CATHOLIC HIGH SCHOOL

Student Self-Medication Authorization Form

Physician Order and Parent /Guardian Authorization for Self-Medication Administration
(**Please complete one form, both front and back for each medication**.)

This **Student Self-Medication Administration form** is required and must be signed by the student's physician/healthcare provider and parent verifying the necessity and student's ability to self-administer the medication appropriately. Please be sure to complete **ALL** the information on this authorization form before returning it to school. This authorization is **valid for one school year and must be renewed at the beginning of each new school year**
Self-Administered medication is defined as epi-pen, inhaler, and insulin. All other authorized medication not administered by the student, will be maintained in the clinic under the supervision of the school nurse.

_____
Student Name: Last First Middle

_____ _____ _____
Date of Birth School Year Grade

PHYSICIAN'S ORDER
1. I have examined this student for (diagnosis): _____ and have determined that he/she requires access to personal emergency medication during school hours.
2. Name of Medication: _____
3. Dosage: _____
4. Route: _____
5. Time(s) to be administered: _____
6. Possible side effects: _____
7. I believe this student is able to carry and administer his or her own medication (excluding controlled substances) at the appropriate time and in the appropriate way. Please check: ____YES _____ NO
8. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____
Physician's Signature Date Signed

_____ _____
Physician's Name (Please Print) Telephone Number

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MARIAN CATHOLIC HIGH SCHOOL

Physician's Address City State Zip Code

PARENT/GUARDIAN STATEMENT

I, the undersigned Parent(s)/Guardian(s) of _____ give consent for my student to self-administer the above medication. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance.

**** Parent /Student are responsible to have the medication available at school.***

_____ _____

Parent/Guardian Name (Please Print) Telephone Number

_____ _____

Parent/Guardian Signature Parent's/Guardian's Address

_____

Date