WYANDOTTE PUBLIC SCHOOLS

PINK

Medication Authorization Form-Physician/Parent Signature for Self-Administration/Self Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original container, be kept in the office in case the student runs out of or forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. The student must carry a copy of this form at school in order to carry their medication. Building administrators and appropriate teachers are informed on a need-to-know basis that the student is permitted to self-possess/self-administer medication.

Student Name: _____ Birthdate: _____ School Year: _____ Start date: _____ Stop date: _____

To be completed by physician:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1.						
2.						

*Route~oral (pill/capsule/chewable/liquid)~inhaled (inhaler, nebulizer)~topical skin application~topical (eyedrop, ointment)~topical ear drop~other (list)

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n. (as needed), list symptoms/conditions under which medication is to be given:_____
The student is capable of _____ self-administering _____ self-possessing the above medication(s)

_____ _____ _____
Physician Signature Date Physician Printed Name

Physician Phone: _____ Fax: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for my child _____ to: _____ self-administer _____ self-possess the above medication(s) according to school district policy and for the physician's staff and school district staff to share information regarding my child's medication needs.

_____ _____
Parent/Guardian Signature Date

Medication Authorization Form-Physician/Parent Signature for Self-Administration/Self Possession
Continued

Student Name: _____
(Please Print)

To be completed by student:

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original properly labeled prescriptive or over the counter container.
3. Take the medication only at the prescribed time, frequency and dose.
4. Carry a copy of this form with me and present it to school staff if asked.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege of self-administration/self-possession will be denied.

_____ _____
Student Signature Date