

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