MEDICATION SELF-ADMINISTRATION AUTHORIZATION FORM

St. Andrew's School Health Center
Phone: 302-285-4240 • Fax: 302-378-8512

This form must be completed in order for the student to self-administer medication on dorm and or self-carry.

- All prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the instructions for use.

CHILD'S FULL NAME: _____ **CHILD'S DATE OF BIRTH**: _____

SECTION A **Prescriber's Authorization:** Medication Shall be Administered during the year in which this form is dated unless more restrictive dates are specified in the medication dosing. This authorization is NOT to exceed 1 year. **From Date:** _____ **To Date:** _____

	Medication Name	Condition Being Treated / PRN parameters	Dose	Route	Frequency	OK to Self Administer	OK to Self-Carry (emerg meds only)
1						☐ yes ☐ no	☐ yes ☐ no ☐ Not emergency med
			Emergency Medication: ☐ yes ☐ no *Known side effects:*				
2						☐ yes ☐ no	☐ yes ☐ no ☐ Not emergency med
			Emergency Medication: ☐ yes ☐ no *Known side effects:*				
3						☐ yes ☐ no	☐ yes ☐ no ☐ Not emergency med
			Emergency Medication: ☐ yes ☐ no *Known side effects:*				

SECTION B **Parent/Guardian Authorization:** I request the authorized staff to allow the self-administration as prescribed on dorm by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the school. I authorize the authorized prescriber on this form to confidentially communicate with the St. Andrew's Health Center staff.

SECTION C **Authorization for Self-Administration / Self-Carry (option):** Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration. I authorize self-administration of all of the medications listed in *Section A* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above following the Health Center guidelines. If indicated in *Section A*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

Prescriber's Name / Title: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:**_____ **Zip Code**_____

Prescriber's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____ **Cell Phone #:**_____

St. Andrew's Health Center reserves the right to revoke the privilege of on-dorm medication self-administration.