DEXTER COMMUNITY SCHOOLS

Medication Prescriber/ Parent Authorization Form for Self-Administration/Self-Possession

Date:_____

Student Name:_____DOB:_____Grade:____Teacher:_____

☐ **For prescription medication**
Top portion completed by health care provider; bottom portion completed by parent/ guardian.
***School administrator and or school nurse must sign for approval of non-emergency prescription medications**.

☐ **For over the counter medication**
Both portions completed by parent/guardian

Medication	Dose	Time	Route	Side Effects	Adverse Reactions

Start Date:_____Stop Date:_____

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

If p.r.n, list symptoms/conditions under which medication is to be given:_____

Student is capable of self-administering: **YES NO**, self-possessing: **YES NO** the above medication.
(circle one) (circle one)

Physician's Phone #: _____ Fax#:_____

Address_____

_____ _____ _____
physician's signature date physician's printed name

To be completed by parent/guardian:

I request and give permission for my child (named above) to self-administer **YES NO** self-possess **YES NO** the above medication (prescription or over the counter-OTC) according to the prescribing health care provider's prescription OR my direction (after consulting our physician for correct dosage) for OTC AND school district policy. I also give permission for the health care provider(s)/ staff and school district staff to share information regarding my child's medication needs. I understand that the medication must be in the original pharmacy/over the counter medication container, labeled with student's name, **and if prescribed medication:** with name of prescribing health care provider, strength and dose of medication, and directions for use. I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medication or treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. I understand that my child agrees to: Never share medication with another person. Carry the medication in its original properly labeled prescriptive container. Take medication only at the prescribed time/frequency and dose, and that they are knowledgeable regarding the dose, desired effects, side effects, and administration of the medication. I understand this privilege may be discontinued by administration for supportable reasons after parental notification.

_____ _____ _____ _____
parent/guardian signature date student signature date

_____ _____
administrator/school nurse signature date

*Signature required for approval to self-carry, non-emergency prescription medications

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