AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL

Name and DOB of student: ________________________________________________

Condition for which the medication is administered: __________________________

Name of Medication: ___________________________ Dose & method: ____________

Time(s) of administration: _____________________________________________

Duration of medication (limit to 1 school year)
Start date: _______________  End date: ____________________________

In my opinion, this student shows capability to carry and self-administer the above medication.

________________________________________  ____________________________
Physician Signature          Date

________________________________________  ____________________________
Physician Printed Name        Physician Phone Number

Parent/Guardian Authorization

I request that ___________________________ be permitted to:  carry / self-administer
(circle one or both)

the above ordered medication. I take responsibility for this permission. I understand that the
medication must be in the original pharmacy container, including the original label indicating the
student’s name, prescribing health care provider, medication name, date of original prescription,
strength and dose of prescription, and directions for use.

________________________________________  ____________________________
Parent/Guardian Signature          Date

________________________________________
Parent/Guardian Printed Name