Revised 06/2017

Lowndes County Public Schools

Medication Self-Administration Documentation and/or Medication Authorized to Keep On Person Documentation

Student Name_____ Grade _____

Name of Medication _____ School _____

- ✓ Standardized Medication Authorization is complete with parent and prescriber affirmation signatures authorizing this student to self administer medication and keep his/her medication on person.
- ✓ Students Individual Health Care Plan is complete

_____ Parent/Prescriber Authorization matches prescription label and the label is intact.

_____ Medication is not expired: Product manufacturer expiration date _____.

_____ Student has knowledge of medication administration and safety, including information addressed in his/her HCP.

_____ Student demonstrates knowledge, skill and experience of his/her chronic illness and medication. He/She verbalizes potential side effects and adverse reactions including when to contact the school nurse or prescriber.

Parent Prescriber Authorization for Self Administration of Medication:

_____ Student agrees he/she is accountable for safe and appropriate self administration of the authorized medication. He/ She has been informed of legal policies and requirements related to self administration of authorized medication and will not give or share medication with another person.

Parent Prescriber Authorization for Medication to Keep on Person:

_____ Student agrees he/she is accountable for safe and appropriate possession of the authorized medication. He/ She has been informed of legal policies and requirements related to possession of authorized medication and will not give or share medication with another person.

Parent/Guardian Signature _____ **Date:** _____

Student Signature _____ **Date:** _____

Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.

Nurse Signature: _____ **Date:** _____