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 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 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 the 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. The student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.

Nurse Signature _____ Date: _____