Student Name: _____ Grade: _____

Self-Administration of Medication Authorization

When a prescribing health professional, parent/guardian, student and school health office personnel/building principal agree that self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully, and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The medication must be brought to school in a container appropriately labeled by a pharmacist or the prescribing health professional.

This form must be completed by the prescribing health professional and parent/guardian and returned to the School Office. Orders must be renewed annually or whenever medication, dosage, or administration changes.

School: Telephone No.: Fax No.:

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that_____ is capable of self-administering the following medication:
(Student's Name)

_____ _____ _____ _____
(Medication) (Route) (Dose) (Frequency)

I recommend self-administration of this medication for the treatment of: _____

_____

Comments: _____

_____

Discontinuation date: _____

_____ _____ _____ _____
(Signature Prescribing Health Provider) (Print Name) (Phone) (Date)

Parent/Legal Guardian's Request and Authorization for Self-Carry/Self-Administration

I, request and authorize my child _____ to carry and/or self-administer
(insert name of student) (circle one or both options)

their medication _____.
(insert name of medication)

This authorization is given based on the following:

- My child is capable of and had been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication.
- I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.

- I understand that this authorization shall be effective for this current school year and must be renewed annually.

_____
Parent/Legal Guardian Name (PLEASE PRINT)

_____ ___ /___/___
Parent/Legal Guardian Signature *Date*

STUDENT AGREEMENT

I agree to:

- Follow my prescribing health professional's orders
- Use correct medication administration technique
- Not allow anyone else to use my medication
- Notify the School Office under the following circumstances:
  - My symptoms continue or get worse after taking my medication
  - I suspect that I am experiencing side effects from my medication
  - Other _____

_____ _____
(Signature of Student) (Date)

Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the building principal.

School Acknowledgement and Notification that _____
(Student's Name)
Will be self-carrying/self-administering his/her medication(s).

Reviewed and accepted by _____ ___/___/___
Licensed School Nurse/Registered Nurse Or *Date*
Responsible School Health Authority