

AUTHORIZATION TO ASSIST STUDENT WITH
SELF-ADMINISTRATION OF MEDICATION

- o Medications will only be administered during school hours if prescription indicates is necessary or is indicated for complaints.
- o It is the responsibility of the Parent/Guardian to bring medication to school in the ORIGINAL container. All OTC meds are to be clearly marked with student name. All PRESCRIPTION medications must be labeled with the pharmacy label indicating Student Name, Medication Name, Dosage, and route, Prescription #, Dispensed Date, ordering Physicians Name, Pharmacy Name and phone number, and expiration date.

PARENTAL CONSENT FOR STUDENT MEDICATION USE:

I request that school personnel assist my student with self-administration of the following medication during school hours.

Student Name _____ Grade _____ Teacher _____

Medication Name _____ Dosage _____

Route of Administration: ☐oral ☐inhalation ☐injection ☐topical

Reason medication is to be administered: _____

Time to be taken: _____ Daily at _____ am / pm
 _____ Every _____ hours as needed

Treatment Duration:

Treatment is to end on _____, _____.

May be used as needed or prescribed during school year.

I declare that my student is competent to self-administer the medication with assistance of school staff and I assume full responsibility for any side effects or complications my child may have as a result of taking this medication.

Parent/Guardian: _____ Date ____/____/____

Phone _____ Emergency Phone _____

[illegible]