



Authorization for Self-Administration/Self-Possession of Medication

Student: _____ DOB: _____ Grade: _____ Date: _____

- Prescription medication (grade 9-12 only)** Top portion to be completed by health care provider
- Over the counter medication (grade 7-12 only)** Both portions completed by parent/guardian

Medication	Dose	Time	Route	Side Effects

- Start Date: _____ Stop Date: _____
- List minimal frequency between doses, be specific for each medication listed above (especially if PRN-as needed): _____
- If PRN, list symptoms/conditions under which medication is to be administered, be specific for each PRN medication listed above: _____

The student is capable of self-administering the above medications: Yes No

The student is capable of self-possessing the above medications: Yes No

Physician's Phone #: _____ Address: _____

Physician's Signature
Date
Physician's Printed Name

To be completed by parent/guardian

Authorization of Parent/Guardian concerning self-administration/ self-possession of all above medications.

1. Medication must be in the original container, labeled with students name. **If prescribed medication-** name of prescribing health care provider, strength and dose of medication, and directions for use.
2. Notify the school immediately if there is any change in the use of the medication or treatment.
3. Student is aware they may never share medication with another person.
4. Take medication only at the prescribed time/frequency and dose.

I request and give permission for my child to self-administer and self-possess the above medication(s) according to the prescribing health care provider's prescription OR my direction (after consulting our physician for correct dosage) AND school district policy. I also give permission for the school nurse to communicate with my child's physician regarding this medication. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. My child is knowledgeable regarding the dose, desired effects, side effects, and administration of the medication. I understand this privilege may be discontinued by administration for supportable reasons after parental notification.

Parent/Guardian signature
Date
Student Signature
Date

Administrator/School Nurse Signature Date

*Signature required for approval to self-carry prescription medications

Revised 6/18/2025