



# Authorization for Self-Administration of Medication by Bend-La Pine Schools Student

DATE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ SCHOOL YEAR: \_\_\_\_\_

Student Name:	Birth Date:	Perm ID:	Grade:
Parent/Guardian:	Relationship to student:	Phone:	
Parent/Guardian:	Relationship to student:	Phone:	
Emergency Contact:	Relationship to student:	Phone:	
Medical Provider:	Medical Organization:	Phone:	
Consulting Nurse:		Phone:	

I give my student permission to carry and self-administer the following medication:

Medication Name:		Type: <input type="checkbox"/> Prescription <input type="checkbox"/> Over the counter		Prescription number (if applicable):	
Start Date:	End Date:	Expiration Date:	Frequency (how often):	Time:	
Dose:	Route: <input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Inhalation <input type="checkbox"/> Ear <input type="checkbox"/> Eyes <input type="checkbox"/> Nose <input type="checkbox"/> Topical <input type="checkbox"/> Other: _____				
Reason for Medication:		Special Instructions:			

**Parent/Guardian Authorization:**

- I verify the above health information is accurate and complete, and I understand it is my responsibility to promptly notify the school office or consulting nurse in writing of any changes to this information.
- I understand a Self-Administration Agreement must be signed by my student and approved by the school’s consulting registered nurse before the student can self-administer medication.
- This authorization applies only to the medication listed above for the duration of treatment and school year indicated.
- **I authorize the exchange of information between Bend-La Pine Schools personnel and my student’s medical provider.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Guardian Name (Printed): \_\_\_\_\_

**Medical Provider Approval – Required\* if the instructions above deviate from the prescription label or manufacturer directions**

Medical Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Medical Provider Approval may be provided in a separate document (e.g. a doctor’s note), which must be attached to this form.

# Self-Medication Agreement

**Student Name:** \_\_\_\_\_ **School:** \_\_\_\_\_ **School Year:** \_\_\_\_\_

Students who are developmentally and behaviorally able, if authorized by their parent/guardian, may keep and self-administer prescription and non-prescription medication subject to the following:

- All medication must be kept in its appropriately labeled, original container. \_\_\_\_\_  
Initials
- Prescription medications must have a label from a licensed pharmacist specifying the student's name, the medication name, and the dose, frequency, and time of administration. \_\_\_\_\_  
Initials
- Non-prescription medication must have the student's name affixed to the original container \_\_\_\_\_  
Initials
- Parent/Guardian is responsible for providing needed medication and maintaining the supply as needed. \_\_\_\_\_  
Initials
- Parent/Guardian accepts responsibility for notifying the school in writing of any changes to the student's medication during the school year and after the date shown on this document. \_\_\_\_\_  
Initials
- Any changes in administration from the prescription label or manufacturer's directions must be approved in writing by the student's health care provider. \_\_\_\_\_  
Initials
- The student may only have in their possession the amount of medication needed for one day. (Exceptions will be made for inhalers, insulin delivery devices, and other medications as approved by the school's consulting nurse.) \_\_\_\_\_  
Initials
- The student may only self-administer their own medication and may not share their medication with another student. \_\_\_\_\_  
Initials
- Permission to self-administer medication may be revoked if the student violates Bend-La Pine Schools policies governing administration of medication. The student may be subject to discipline, up to and including expulsion. \_\_\_\_\_  
Initials

**I have read and agree to the above regulations and give my student permission to carry and self-administer their medication.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Guardian Name (Printed): \_\_\_\_\_

**I have read and agree to follow the regulations outlined above:**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by the school's consulting Registered Nurse:**

- Student has demonstrated they are developmentally and behaviorally able to self-administer the medication.
- Student has verbalized understanding of the reason for taking the medication.
- Student has verbalized understanding of the medication dose, route, time, and frequency.
- For inhalers and injectable medication:**
- Student has demonstrated how to correctly administer the medication.

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Name (Printed): \_\_\_\_\_