

Bloomfield Hills Schools
Authorization for Non-Prescription Medication: Self-Carry/Self-Administration

This form must be completed fully in order for any medication to be administered at school. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or instructions.

- Students in grades 6-12 may be granted permission to self-carry and self-administer non-prescription medication at school.
- Non-prescription (over the counter) medication should be in the original container if possible with the label intact.
- Students' names and date of birth must be on the medication.
- All non-prescription medications granted permission for self-carry/self-administer require a parent/guardian signature.
- A student may transport medication to and from school if permission to self-carry/self-administer is granted.
- A student who has been approved to self-carry medication may have in his/her possession only the quantity of medication needed for that school day, unless otherwise approved, in writing, by the building administrator.
- Students who self-carry should never share their medication with anyone else.
- The district reserves the right to determine that a student may not self-carry for any reason.

To be completed by the student's parent or guardian

Student Name: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose (no ranges): _____

Route: ☐ By Mouth ☐ Inhaled ☐ Topical ☐ Nasal ☐ Eyes ☐ Ears Other: _____

Time of administration: _____ If as needed, frequency: _____

If as needed, for what symptoms: _____

Relevant side effects: ☐ None Expected ☐ Specify: _____

Medication shall be administered from: (Month/day/year): _____ to _____

Self Carry/Self Administration of Medication Authorization/Approval

- *I certify that I have legal authority to consent for medical treatment for the student named above, including the administration of medication at school.*
- *I give my permission for my student to carry this medication on his/her person and self-administer the medication.*
- *I hereby release from liability and agree to indemnify any school personnel for any action or inactions associated with the administration of medication by the above student.*

This student may carry this medication on their person: ☐ YES ☐ NO

This student is capable and responsible for self-administering this medication: ☐ YES ☐ NO

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

To be completed by the Student

I have been instructed by my parent/guardian on the proper administration of this medication. I understand the symptoms that warrant taking this medication, and I understand how much of this medication to take. I will not allow another student to take my medication under any circumstances. I understand that I may no longer be permitted to self-carry and self-administer this medication and be subject to disciplinary consequences if I violate this agreement and district policy.

Student Signature: _____ Date: _____