



Self-Carry Medication Authorization Form

This form is not valid for controlled substances such as ADHD medications, pain medications, or other regulated prescriptions. Please contact your child's school administrator for details on administering these medications.

I agree to:

- a. Never share my medication with another person.
- b. Carry the medication in its original, properly labeled prescription/over-the-counter container.
- c. Take medication only at the prescribed time/frequency and dose.
- I am knowledgeable regarding the dose, desired effects, side effects, administration, etc., of the medication(s). I understand that if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and my privilege(s) of self-administration/self-possession denied.

Student Name: _____ **School:** _____ **Grade:** _____

Medication #1

- Name of Medication: _____
- Dosage: _____
- Route (e.g., inhaled, oral, topical): _____
- When is medication taken (morning, afternoon, as needed): _____

Medication #2

- Name of Medication: _____
- Dosage: _____
- Route (e.g., inhaled, oral, topical): _____
- When is medication taken (morning, afternoon, as needed): _____

Medication #3

- Name of Medication: _____
- Dosage: _____
- Route (e.g., inhaled, oral, topical): _____
- When is medication taken (morning, afternoon, as needed): _____

Student Signature: _____ **Date:** _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____