TRENTON PUBLIC SCHOOLS

Medication Self-Administration Authorization Form

To be completed by the physician/licensed prescriber and parent/guardian for student self-administration of medication.

- Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. Medication must not be expired.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____

SCHOOL / BUILDING: _____ **GRADE:** _____

TO BE COMPLETED BY THE PHYSICIAN / LICENSED PRESCRIBER

Medication Name	Dosage	Route	Time & Frequency

Form of medication: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

Order start date: _____ Order end date: _____

If no end date is indicated, orders expire at the end of the current school year.

1. This student is capable and responsible for self-administering this medication:

☐ No ☐ Yes

2. The prescriber has instructed the student on appropriate use and side effects:

☐ No ☐ Yes

3. Additional instructions / storage requirements: _____

☐ On back of form ☐ Attached ☐ None

Prescriber signature: _____ Date: _____

Printed name: _____ Phone: _____

TO BE COMPLETED BY THE PARENT / GUARDIAN

I authorize my child to self-administer the medication listed above and to carry it only as authorized by the prescriber. I understand that a school building administrator may discontinue the self-administration privilege if it is violated.

Student responsibilities:

1. Keep the medication on the student at all times when authorized to carry it.
2. Do not share medication with any other student.
3. Take the medication according to the prescribed directions.

I am responsible for supplying the medication.

Student signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

Relationship: _____ Phone: _____

Please return this form to Katie Szczepaniak, RN - District Nurse

at szczepaniakk@trentonschools.com or return in person to the health para/main office of your student's school.