Self-Administration of Medication Authorization
School Year: ___________

To Be Completed By Prescribing Health Professional

It is my professional opinion that ____________________________ is capable of carrying & self-administering the following medication:

____
Medication Dose Route Frequency

I recommend self-administration of this medication for the treatment of ________________________.

Comments:____

Discontinuation date:_______________________________________

____
Health Care Provider Signature

_________________________________ _________________________________ ______________
Printed Name Phone # Date

To Be Completed By Parent/Guardian

I, request and authorize my child ________________________ to carry and/or self-administer their medication __________________________________.

This authorization is given and based on the following:
I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication. I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to my child's health/medications between the building nurse and the prescribing health professional/clinic.

____ _________________
Signature of parent/guardian Date

Student Agreement

Medication is permitted in accordance with district policy and procedure(s). In addition to the parent/legal guardian, the student's licensed prescriber/physician must authorize self-carried/administered medication. Student name must appear on the medication container, inhaler, or injector.

I,______________________________ agree to the responsibilities of carrying medication.

_____ The student can demonstrate correct use/administration.
_____ The student can recognize correct dosage.
_____ The student recognizes proper and prescribed timing for medication.
_____ The student agrees to not share the medication with others.
_____ The student will keep the medication in an agreed upon location.
(please indicate location)__________________________
_____ The student will keep a second labeled container in the health office. (optional)
______ The student will notify the Health Service Office under the following circumstances:

- Symptoms continue or get worse after taking my medication
- Suspect that I am experiencing side effects from the medication
- Other ______________________________________

____ _____________
Signature of Student Date

Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Building Principal and District Nurse.

To Be Completed By Registered Nurse/Licensed School Nurse

The student is / is not able to demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.

_____________________________________ ___________________
RN/LSN Signature Date