Medication Prescriber/Parent Authorization Form for Self-Administration/Self-Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. The school district recommends that in addition to the medication carried, an extra spare medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out/forget medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. The student must carry a copy of this form at school.

Student Name: _____ Birthdate: _____ Teacher: _____ Grade: _____ School Year: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be given	Form/Route	Side Effects	Adverse Reactions
1						
2						

* Routes ~ Oral (PO) (pill/capsule/chewable/liquid) ~ Inhaled (inhaler, nebulizer) ~ Topical (skin application/ointment) ~ Eye drops or Ear drops ~ Intramuscular (IM) ~ Subcutaneous ~ Rectal

List minimal frequency between doses (especially if p.r.n): _____

If p.r.n. (as needed), list symptoms/conditions under which medication should be given/taken: _____

Reasons for medication use (diagnosis) (optional): Medication #1_____ #2_____

The student is capable of ☐ self-administering ☐ self-possession the above medication (s)

Start date (if not beginning of the school year):_____ Stop date: (if not end of school year): _____

_____ _____ _____

Physician's signature Date Physician's Printed name

Physician's Phone #_____ Fax#: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for (named above) to of ☐ self-administering ☐ self-possession the above medication/treatment(s) at school according to standard school district policy. I give permission for the physician(s)' staff and school district staff to share information needed to assist my child with medication needs.

Parent Signature _____ Date_____

Student Name_____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original, properly labeled prescriptive/over-the counter container
3. Take medication only at the prescribed time/frequency and dose
4. Carry a copy of this form with me and present it to school staff if asked.

I am knowledgeable regarding the dose, desired effects, side effects, administration of the medication (s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege of self-administration/self-possession denied.

_____ _____

Student Signature Date