Self-Administration of Medications

School Year: _____

Student Name:	Grade:
Parent/Guardian Phone # (please specify)	

Authorization for Prescription Medication Completed **Name of Provider & Contact Information:**	

To Be Completed by Parent/Guardian

I give my permission for my child to self-carry and self-administer during school hours as prescribed by my child's health provider. Should the need arise I give permission for the Licensed School Nurse to contact the health provider with questions or concerns. I will notify the school of any changes to the above medications, and supply new forms. My child will sign and follow the self-administration agreement. The medication will be supplied in the original prescription bottle/container/syringe with the student's name on it. I release the school personnel from liability in the event that an adverse reaction would occur as a result of taking the medication. If I choose, a supplemental bottle of the medication may be provided and stored in the school office (this must have the original or prescription label on it).

Signature of Parent/Guardian: _____Date:_____

To Be Completed By Student:

I agree to:

- Follow my prescribing health provider's medication order
- Use correct medication administration technique
- Maintain a written record of my medication administration while in school if requested
- Not allow anyone else to use my medication
- Keep a supply of my medication with me in school and on field trips
- Notify the school office if any of the following occur:
    - Symptoms continue or get worse after taking medication
    - Symptoms re-occur within 2-3 hours after taking medication
    - Suspect that I am experiencing side effects of my medication
    - Other:

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the safety items listed above.

Signature of Student: _____ Date: _____

Signature of Licensed School Nurse: _____ Date: _____