

Self-Administration of Medication Authorizations

Parent/Guardians Request and Authorization for Self-Administration

I request and authorize my child _____ to carry and/or self-administer
(insert name of student) (circle one or both options)
his/her medication _____
(insert name of medication)

Medication is permitted in accordance with district policy and procedure(s). Student name must appear on the medication container, inhaler or injector.

Responsibilities for carrying medication:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | The student can demonstrate correct use/administration. |
| <input type="checkbox"/> | <input type="checkbox"/> | The student recognizes proper and prescribed timing for medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | The student agrees to not share medication with others. |
| <input type="checkbox"/> | <input type="checkbox"/> | The student will keep the medication in an agreed upon location(s)
(please indicate location) _____. |
| <input type="checkbox"/> | <input type="checkbox"/> | The student will keep a second labeled container in the health office.
(Optional, based on district policy and procedure(s)) |
| <input type="checkbox"/> | <input type="checkbox"/> | The student agrees to come directly to the health office if having the following symptoms after using medication:
_____ |

The student is is not able to demonstrate the specified responsibilities.
 Yes No The student may carry the medication unless and until he/she fails to follow the above agreement.

Signature of Parent/Legal Guardian

Date

Signature of Student

Date

Physician's/Licensed Prescriber's Authorization to Self Carry/Self Administer

I certify that _____ has a medical condition and/or potentially life-
(Student's name)
threatening illness _____, and this student is capable of and has
(Specify illness or condition)
been given instruction in the proper method of self-administration of _____
(Name of medication)

(PLEASE PRINT) Licensed Prescriber/Physician's Name

Date

Licensed Prescriber/Physician's SIGNATURE

Phone

Address

Fax

Reviewed and accepted by: _____
Licensed School Nurse/Registered Nurse

Date