

Over the Counter Pain Medications

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 **original** medication container.

Responsibilities for carrying medication:

Yes No

- The student can demonstrate correct use/administration.
- The student recognizes proper and prescribed timing for medication.
- The student agrees to not share medication with others.
- The student will keep the medication in an agreed upon location(s)

(please indicate location) _____

- The student will keep a second labeled container in the health office.
(Optional, based on district policy and procedure(s)).

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