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	
[ ]	[ ]	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 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*