MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM FOR SELF POSSESSION

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction of 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. For medication other than inhalers, only that day's supply of medication is to be carried. The School District recommends that spare medication, properly labeled in its original container be kept in the clinic/office in case the student runs out/forgets the medication. The building administration 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/Counselor: _____ School: _____ Grade: _____ School Year: _____

Address:_____City: _____ Zip:_____

To be completed by physician/licensed prescriber:

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

Routes ~ oral (pill/capsule/chewable/liquid) ~ inhaled (inhaler/nebulizer) ~ topical (eye drops, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if P.R.N.): _____

If P.R.N., list symptoms/condition under which medication is to be given: _____

Reason for medication (optional): Medication #1: _____ Medication #2: _____

Special instructions: _____

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

Physician's Signature: _____ Date: _____Physicians Printed Name:_____

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

To be completed by parent/guardian:

I request and give permission for above named child to receive the above medication(s)/treatment at school according to standard School District policy and for the physician('s)/staff and School District staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container.

Parent Signature: _____ Date: _____ Phone Number: _____

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) Keep a copy of this form and back-up medication in the school office/clinic. I am knowledgeable regarding the dose, desired effects, side effects, administration, etc., 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/guardians, and the privilege of self-administration /self-possession denied.

Student Signature: _____ Date: _____

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM

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

Address:_____City: _____ Zip:_____

To be completed by physician/licensed prescriber:

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

Routes ~ oral (pill/capsule/chewable/liquid) ~ inhaled (inhaler/nebulizer) ~ topical (eye drops, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if P.R.N.): _____

If P.R.N., list symptoms/condition under which medication is to be given: _____

Reason for medication (optional): Medication #1: _____ Medication #2: _____

Special instructions: _____

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

Physician's Signature: _____ Date: _____Physicians Printed Name:_____

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

To be completed by parent/guardian:
I request and give permission for above named child to receive the above medication(s)/treatment at school according to standard School District policy and for the physician('s)/staff and School District staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container.

Parent Signature: _____ Date: _____ Phone Number: _____