VAN BUREN PUBLIC SCHOOLS

ADMINISTRATION BUILDING

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Medication Prescriber/Parent Authorization Form for Self-Administration/Self-Possession 2021-2022 School Year

(A new form is required yearly for each medication)

Student Information

Student's Name: _____ Date Of Birth: _____

Building: _____ Grade: _____

Healthcare Provider Written Authorization/ Information

The section must be completed by the student's healthcare provider

Name/Title: _____

Address: _____

Telephone: _____ Fax: _____

Attach to this form the Student's healthcare provider's written authorization for the Student to possess and administer this medication.

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or 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 or forgets the medication. The building administrator 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.**

Medication Name: _____ Dose: _____

Administration Method: _____ Administration Time/Frequency: _____

If *as needed* under what conditions is the medication to be administered: _____

_____

Relevant Side Effects: _____

Start Date: _____ End Date: _____

Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions

If p.r.n., list symptoms/conditions under which medication is to be given: _____

The student as listed above capable of { } self-administering { } self-possessing the above medication(s)

_____ _____ _____

Physician's Signature Date Physician's Printed Name

Physician's Phone #: _____ Fax #: _____

Address: _____

Parent/Guardian Consent

I, _____, authorize school staff to administer medication accordance with this form and applicable policies. I acknowledge that Board Policy requires that I immediately inform the District of any changes to the healthcare provider's medication instructions.

I request and give permission for my child (named above) to: **( ) self-administer ( ) self-possess** the above medication according to school district policy and for the physician staff and school staff to share information regarding my child's health and medication needs.

Parent's/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(Circle which phone number you would like District staff to call first)

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(s) of self-administration/self-possession denied.

Signature_____ Date _____