Self-Medication Authorization Form

Prescriber's Authorization

Patient's Name____ Sex__________

Date of Birth ____ /____ /________ Teacher/Homeroom______________________________

Condition for which medication is being administered__________________________________

Medication Name________________________ Dose__________ Route______________

Times(s) of day to administer____

Is this a PRN, (As-needed) Medication? YES NO

Medication shall be administered from: ___ /___ /______ to: ___ /___ /______

The student has demonstrated that they are capable of self-administering their medication: YES NO If

NO, then please explain____

Prescriber's Name_________________________________ Telephone_____ - _____ - ______

Address____

Prescriber's Signature_______________________________________ Date_____________

Parent/Guardian Authorization

I ______________________ parent / guardian of _________________________request that school health staff allow my child to self-carry with the intention to self-administer the medication described above by my child's health care provider.

I agree to notify the school nurse or school health staff and provide a new self-medication authorization form when there is a change in my child's medication, health status, or authorized healthcare provider.

Describe how your child will carry/store their medications________________________________

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Parent/Guardian Signature___________________________________ Date_____________

Cell Phone____ - ____ - ______ Home Phone____ - ____ - ______ Work Phone____ - ____ - ______