Health Network for Rural Schools
Authorization for Self - Administration of Medication

To: ______________________________________
(School Name)

Student: ____ **DOB:** ___________ **Grade:** _________

Parent: ____ **Phone:** __________________________

Teacher: __________________________________ __________________________

I am giving my child permission to self-administer the following medication as directed below:

Parent/Physician to complete:

Medication: _______________________________

Dose (how much): __________________________

Frequency (how often): ______________________

Route: Mouth Ear Eye Nose Skin

Time: ____________________________________

Duration: Start Date __________ End Date __________

( ) Non-prescription

( ) Prescription Rx number ____________

( ) Please allow my child to self-administer medication. Refer to district policy on self medication. Complete reverse side.

Medications must be from a legal pharmacy, in the original container, identified with the student's name and physician, and include instructions.

Reason for Medication: ____

Special Instructions: ____
____
____

Parent Responsibility – Provide and ensure medication is properly identified. Notify the school in writing of any changes related to this agreement, including the medication being discontinued.

School Responsibility – The school assumes no responsibility for maintaining records related to the student using this medication (date, time of dose, etc.)

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information as necessary, between the school nurse, appropriate school personnel, and my child's health care provider.
Parent/Guardian Signature: ____ **Date:** __________

I have prescribed the above medication. Instructions in the box are accurate. Special instructions including adverse reaction and action required: ____
____
Physician's Signature: (if adding comments) ________________________________ **Date:** _________

HEALTH NETWORK for RURAL SCHOOLS
Self-Medication Agreement

Students who are developmentally and/or behaviorally able will be allowed to self-administer prescription and non-prescription medication subject to the following criteria:

1. **Parental permission by completing the *<u>Authorization of Medication Administration</u>* form for each medication to be self-administered.**

2. **Medications must be in appropriately labeled, original container:**
   * **Student's name**
   * **Name of medication**
   * **Dosage**
   * **Route**
   * **Frequency or Time of administration**
   * **Special Instructions**

3. **The student may have in his/her possession only the amount of medication needed for that school day. A larger supply may be checked into the office.**

4. **Sharing and/or borrowing medication with another student is strictly prohibited.**

5. **Permission to self-medicate may be revoked if the student violates school district policy governing administration of non-injectable medication and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as appropriate.**

I have read and agree to the above criteria and give permission for my child to carry and self-administer his/her medication.

Parent: ____ **Date:** ________________

I agree to comply with the above criteria.

Student: ____ **Date:** ________________

Building Administrator: ______________________________ **Date:** ________________