Authorization to Self-Carry/Self-Administer Medication

Name:_____ Birth date:_____
(last) (first) (middle)

School:_____ Grade: _____

When a prescribing health professional, parent/guardian, student and nurse at school agree that self-carry/self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school.

Orders must be renewed annually or whenever medication, dosage, or administration changes.

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that _____ is capable of self-carrying / self-administering **(circle choices)** the following medication:

_____

Medication Route Dose Frequency

_____

Medication Route Dose Frequency

I recommend self-administration of this medication for the treatment of: _____

Comments: _____

_____

Discontinuation date: _____

Physician's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for my child to self-carry / self-administer **(circle choices)** medication at school as prescribed by my child's physician and I authorize reciprocal release of information related to the medication between the school nurse and the physician/clinic. The information I provide will be shared only with staff in the school whose jobs require access to this information to ensure my child's safety and school success.

Signature of Parent/Guardian_____ Date: _____

Daytime Phone Number: _____ Cell/pager number: _____