# Authorization for Students to Self–Carry & Self-Administer Medication

Student's name _____

School year: _____ Grade_____

## To Be Completed by Parent/Guardian

I, request and authorize my child _____to carry and/or self-administer their medication.

This authorization is given based on the following:

- I hereby give permission for my child to self-administer prescribed medication at school.
- I authorize release of information related to my child's health/medications between the school nurse and the prescribing healthcare provider.
- I understand that my child shall be permitted to carry their medication at all times providing they do not misuse the medication.
- I understand that if my child misuses the medication, school employees will take the medication and terminate this agreement.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.

Medication name_____

Dosage_____

Frequency_____

For the treatment of _____

Special Instructions or Comments_____

Prescribed by Health Care Provider _____

_____

Print name Phone

_____

Parent /Guardian Signature Date

## To Be Completed by Licensed School Nurse

- ☐ The student can demonstrate correct use/administration.
- ☐ The student can recognize correct dosage.
- ☐ The student recognizes prescribed timing for medication.
- ☐ The student agrees to not share the medication with others.
- ☐ The student will keep a second labeled container in the health office.

The student (is/ is not) able to demonstrate the specified responsibilities. The student (may/ may not) carry the prescribed medication.

_____Date_____

Licensed School Nurse name