

Self-Administration of Medication Authorization

Date _____

Student Name: _____

DOB: _____

Parent(s): _____

Medication Name: _____

Dosage/Route: _____

Time to be Administered: _____

Special Directions: _____

Parent Signature

Date

Dear Dr. _____,

Discussion has taken place with the above-named student and his/her parent(s) regarding the possibility of self-administration of the above-named medication, without the supervision of school personnel. Special directions that would need to be followed in the school setting have been discussed with the student to assist in assuring the safety needs of this student and other students within the building.

Please fill out the following information regarding the authorization of the self-administration if you feel this is appropriate for this student.

___ I **do not** authorize self-administration of the above medication without the supervision of school personnel.

___ I **do** authorize self-administration of the above medication without the supervision of school personnel.

Special Directions: _____

Dosage and Frequency: _____

Any further comments or suggestions: _____

Physician's Signature

Date

*****This permission can be relinquished if proper procedures and handling of medication are not carried out.*****

Return to: _____ School Nurse

_____ School

_____ Address

NS13.10
Revised 10/01

___ Special directions and care of medication has been discussed with the above student.

School Nurse

Date