Health Services Self-Medicating Authorization Form
School Year _____

Authorization from the student's prescriber, parent, and student are required for self-medicating.

***Students will not be permitted to self-carry or self-administer medications that are classified as Controlled Substances.**

Child's Full Name:	**DOB:**	**Grade:**	**Teacher:**	**School:**
List the Medication(s) to be Self-Administered:		**List Medical Diagnosis for which the student is to Self-Medicate:**		

In the section below, please read and initial each statement concerning the above medication indicating you agree. All are required in order to self-medicate.

HEALTH CARE PROVIDER **To be completed by prescriber**	**PARENT AUTHORIZATION** **To be completed by the legal guardian**	**STUDENT AUTHORIZATION** **To be completed by the student**
1. The student named above has been instructed regarding the appropriate use of the medication(s) noted above (i.e., indications, actions, side effects, when to take the medication, when to seek assistance). _____ 2. The student named above has demonstrated competency for safely self-administering the medication(s) noted above. _____ 3. I agree that the student named above should be allowed to possess and self-administer the medication(s) noted above while in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____ 4. This student does not require adult supervision to take this medication._____	1. I authorize my child to possess and self-administer that medication(s) noted above as prescribed while in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before school or after school activities on school property. _____ 2. My child has been instructed about the proper use of the medication(s) noted above. _____ 3. My child has shown me that he or she can safely self-administer the medication(s) noted above. _____ 4. My child and I will be responsible for the proper use and safe-keeping of the medication. _____ 5. I will not hold the school district or any of its employees or agents liable if an injury occurs related to my child self-medicating. I will be responsible for any costs related to any claims that occur related to my child self-medicating. _____ 6. I understand that my child will lose the privilege to self-medicate if he or she endangers him– or herself or another student by misusing the medication(s). _____ 7. I understand that my child may only self-administer the medication(s) noted above. All other medications must be given to my child by a school employee. _____ 8. I understand that my child must keep the medication(s) in the container provided and labeled by the pharmacy or my child's prescriber. It must have my child's name, medication name and dose, and the directions for proper use on it. _____	1. I know when I should and when I should not take the medication(s) noted above. _____ 2. I know the signs and symptoms that may mean that I should not take the medication(s). _____ 3. I know how much of the medication(s) noted above I should take. _____ 4. I know how to take the medication(s) noted above. _____ 5. I will take the medication(s) the way that my prescriber has instructed. _____ 6. I will keep the medication in the package provided by the pharmacy or my prescriber. _____ 7. I will keep the medication and any supplies needed for taking the medication(s) with me in a safe place. _____ 8. I will not allow other students to touch or hold my medication(s) nor any of the supplies needed for taking the medication. _____ 9. I understand that I will no longer be able to take my medication on my own if I endanger myself or another student by misusing the medication(s). _____ 10. I understand that I can only take the medication(s) noted above on my own. All other medication(s) must be given to me by a school employee.
Prescriber's Signature:	**Parent's Signature:**	**Student's Signature:**
Date:	**Date:**	**Date:**

***A new authorization form for self-medicating must be completed each school year.**

***An approved Individual Health Care Plan and Prescription Permission Form are required to be completed with this form.**

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