



Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

District policy states that medications, including over-the-counter medications, may be self-administered to students only upon written request of the student’s physician and parent/guardian. All medications must be brought to and from the school office by the parent/guardian in the original container or one properly labeled by the pharmacy or physician. The label must include the student’s name, physician, name of medication, dosage and time to be self-administered. The school must be notified in writing of any changes. This form must be completed and returned to the health office before medication can be taken. The school district retains the discretion to reject requests for self-administration of medications. For self-administration of asthma medications, please see form [7:270-Ea. Authorization for Self-Administration of Asthma Medication](#). For self-administration and/or self-carry of an epinephrine injector, please see form [7:101-E25b Authorization for Self Administration of Epinephrine Auto-Injector Medication](#).

My child requires medication that must be taken during school hours. I authorize the school to supervise the self-administration of this medication in the dosage and the time listed. I understand that my name on this form constitutes a waiver by me to the school staff for liability for untoward reactions when the medication is self-administered in accordance with the physician’s directions. I understand that in the registered nurse’s absence, self-administration under supervision by the principal’s designee may be necessary.

**I have read and consent to the school medication policy.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Telephone Number of Parent/Guardian

**Physician’s Order and Authorization/Careplan  
ONLY ONE MEDICATION PER FORM**

Name of Student: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time of Administering: \_\_\_\_\_ Length of Time: \_\_\_\_\_  
(i.e. # of Days, School Year)

Diagnosis for which medication is prescribed: \_\_\_\_\_

Expected therapeutic effects of medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician

\_\_\_\_\_  
Telephone Number

**This authorization is valid for one (1) year from the date of the physician’s signature.**