Permission for Possession and Self-Administration of Medication / Diabetic Supplies

Student Name _____Date of Birth _____
School _____ Grade _____School Year _____
List any known drug allergies/reactions _____

PRESCRIBER AUTHORIZATION
Name of Medication _____Reason for Medication _____
Dosage_____ Route _____Frequency/Time(s) to be given _____
Begin Medication Date _____End Medication Date _____

Special Instructions:
Does Medication require refrigeration? Yes _____ No _____
Is the medication a Controlled Substance? Yes _____ No _____
Is the Medication Permitted and recommended for this student? Yes _____ No _____
If asthma Inhaler or Emergency Medication, do you recommend this medication be kept "on person" by the student? Yes _____ No _____
I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication. Yes _____ No _____

Potential Side Effects/Contraindications/Adverse Reactions: _____
_____

Treatment in the event of an adverse reaction: (Attach additional sheet if needed):
_____

_____ _____ _____ _____
Signature of Prescriber Date Phone FAX

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his attending physician. My student and I understand and agree to abide by the district's policy for self carried medications at school. I understand that additional parent/prescriber signed statements will be necessary if the dosage and/or medication is changed. I also authorize the school nurse to speak with the prescribing physician or pharmacist should a question arise about the medication.

_____ _____ _____ _____
Signature of Parent/Guardian Date Contact phone # 1 Contact Phone #2