

**AUTHORIZATION FOR SELF-ADMINISTRATION OF
MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES**

A. To be completed by the licensed healthcare provider:

Student's name: _____ has been instructed in the proper use of

the following medication (s): _____

**IN MY PROFESSIONAL OPINION, THIS STUDENT SHOULD BE ALLOWED TO CARRY AND
SELF-ADMINISTER THE ABOVE MEDICATION (S)**

Licensed Health Care Provider's Signature

Date

B. To be completed by the parent or guardian:

I request that my child _____ be permitted to carry the above prescribed medication (s) on his/her person or to keep the above prescribed medication(s) in her/her locker or PE locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. The student understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

Parent/Guardian Signature

Date



The licensed health care providers statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

School Nurse Signature

Date

NOTE: this form must be completed *in addition* to the parent and prescriber's authorization form for administration of medication in school.

Date form received in health office _____