(Local Education Agency)

Medication Self-Administration Documentation
and/or
Medication Authorized to Keep On Person Documentation

Student Name __________________________  Grade ______  School Year: ____________

Transportation: *Bus #_____ Car rider _____ Drives self _____ *Extracurricular: _______________________

Name of Medication ____________________________________________ School ______________

☑ Standardized Medication Authorization is complete with parent and prescriber affirmation
  signatures authorizing this student to self-administer medication and/or keep medication on person.

☑ Students Individual Health Care Plan is complete

______ Parent/Prescriber Authorization matches prescription label and the label is intact.

______ Medication is not expired: Product manufacturer expiration date ________________

______ Student has knowledge of medication administration and safety, including information
  addressed in his/her HCP.

______ Student demonstrates knowledge, skill and experience of his/her chronic illness, right
  medication, right time, right dose, right route, and right reason.

______ Student verbalizes potential side effects and adverse reactions including when to contact the school
  nurse or prescriber.

Parent Prescriber Authorization for Self Administration of Medication:

______ Student agrees he/she is accountable for safe and appropriate self administration of the authorized
  medication. He/ She has been informed of legal policies and requirements related to self administration of
  authorized medication and will not give or share medication with another person.

Parent Prescriber Authorization for Medication to Keep on Person:

______ Student agrees he/she is accountable for safe and appropriate possession of the authorized
  medication. He/ She has been informed of legal policies and requirements related to possession of authorized
  medication and will not give or share medication with another person.

Student Signature ____________________________________________ Date: ______________________

Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own
medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her
prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience
of his/her chronic illness and medication.

Nurse Signature: ____________________________________________ Date: ______________________

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