

**(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:** \_\_\_\_\_

Date	Nurse Notes

