Medication Authorization - Self-Administration
Hillcrest Lutheran Academy
School Year _____

All medications must be in original, labeled containers (in English), emergency medications and over-the-counter medications

Student Name _____School Year_____

Date of Birth_____Grade_____

Medication	Strength	Dose	Time	Route

Signature of Physician/License Prescriber:_____

Name of Physician/Licensed Prescriber:_____Date:_____

Clinic Address:_____

Clinic Phone #:_____Fax #:_____

Medical Condition:_____

Possible Side Effects or Other Considerations:_____

Expected Duration of Treatment:_____

Parent/Guardian Authorization

1. I request my child be allowed to self administer the above medication(s) during school hours and on field trips, as ordered by physician/licensed prescriber.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any changes in the medication(s). (ex:dosage change, medication discontinued).

4. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions about the above listed medication(s) or condition(s).
5. I give permission for the school nurse to communicate with the child's teachers about the child's health condition(s) and the action of the medication(s).
6. I give permission for the medication to be given by designated personnel delegated by the school nurse.

Additionally, I understand the following guidelines must be adhered to in regard to self administration:

- The medication must be an emergency or maintenance medication for a specific condition outlined in the student's health plan created by parents, doctor and school nurse. (Diabetes, asthma, anaphylaxis, ….)
- The medication may NOT contain ephedrine or pseudoephedrine as its sole active ingredient or as one of its active ingredients.
- The medication must be used as prescribed or labeled on the original container. The medication must be brought to school in a properly labeled bottle.
- The student must NOT share the medication with anyone else.

If my student does not follow the above guidelines, I understand that his/her permission to carry and self-administer the medication may be taken away.

_____ _____/_____/_____

Parent/Legal Guardian Signature **Date**

Student Agreement

I agree to:

- Follow my prescribing health professional's orders
- Use correct medication administration technique
- Never allow anyone else to use my medication
- Keep a current supply of my medication located_____

Notify the School Health Office under the following circumstance:

- My symptoms continue or get worse after taking medication
- I suspect that I am experiencing side effects from my medication
- A change in dose or frequency _____

_____ _____/_____/_____

Signature of Student **Date**

School Acknowledgement and Notification that the above mentioned student will be self carrying/self-administering his/her medication(s).

Reviewed and accepted by _____ _____/_____/_____

Licensed School Nurse/Registered Nurse **Date**