MASON CONSOLIDATED SCHOOLS

Medication Prescriber/Parent Authorization Form Including Self-Administration/Self-Possession

Student name: _____ Birth date: _____ Teacher: _____ Grade: _____ School year: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be Given	Form/Route*	Side Effects	Adverse Reaction
1.						
2.						

***Routes:** Oral (pill/capsule/chewable, liquid); inhaled (inhaler, nebulizer); topical skin application; topical (eye drop, ointment); topical ear drop; injection; other (list)

Report side effects to the doctor's office immediately.
List minimal frequency between doses (especially if p.r.n): _____
If p.r.n. – list symptoms/conditions under which medication is to be given: _____

Reason for medication (*optional)*: Medication #1: _____ Medication #2: _____

Special instructions (storage/sterility requirements/probable side effects): _____

Start date (if not beginning of school year): _____ Stop date (if not end of school year): _____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

Physician's phone number: _____ Fax number: _____ Address: _____

To be completed by parent/guardian:
I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist with my child's medication needs. I will assume responsibility for safe delivery of the medication to school (schools require parent/guardian to bring medication in its original container). I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian signature: _____ Date: _____

Home phone: _____ Work phone: _____

Principal's signature: _____ Date: _____

Self-Administration / Self-Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without any additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advance notice to the parent/guardian. The student must carry a copy of this form at school.

To be completed by parent/guardian:

I request and give permission for my child (named below) to [ ] self-administer [ ] self-possess the above medication(s) according to school district policy and for the physician(s)/staff and school district staff to share information regarding my child's medication needs. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian signature: _____ Date: _____

Home phone: _____ Work phone: _____

Student's name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person;
2. Carry the medication in its original, properly labeled prescriptive/over-the-counter container;
3. Take medication only at the prescribed time/frequency and dose;
4. Carry a copy of this form with me and present it to school staff, if asked.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and the privilege(s) of self-administration/self-possession denied.

Student's signature: _____ Date: _____