Student Self Medication Administration Form

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION
(Please complete one form for each medication.)

Student's Name: ____ DOB: ________________________

Allergies: ____

Medication: ____ Dosage: _______________________ Route: ___________________

Reason for medication or diagnosis: ____

School Year: __________

Self-administration of medication by student
Only emergent/urgent medication will be considered for self-administration by a student. The student will be evaluated on an individual basis regarding the need to carry emergency medication. This **Student Self Medication Administration** form is required and must be signed by the student's physician/healthcare provider and parent verifying the necessity and student's ability to self administer the medication appropriately. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis): ____ and have determined that he/she requires access to personal emergency medication during school hours.

2. Name of Medication ________________________________

3. Dosage & Route: __________________________

4. I believe this student is able to carry and administer his or her own medication (excluding controlled substances) at the appropriate time and in the appropriate way.

Please check: ____YES _____ NO *I understand that self-administered medication is not provided by or monitored by the school staff.

Physician's Signature: _______________________________________ Date: _____ / _____ / _____

Printed Name: ____ Phone: ______________________

PARENT/GUARDIAN STATEMENT
I, the undersigned Parent(s) Guardian(s) of ____ give consent for my student to self-administer the above medication. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the KORE office and school staff. * Parent / Student are responsible to have the medication available at school.

X ____ ____ / ____ / ____
(Parent/Guardian Signature) Date

Home Phone: _____________________________Work: ________________________Cell: ___________________________