AUTHORIZATION FOR STUDENT INDEPENDENT SELF-ADMINISTRATION OF MEDICATION

(A separate form must be completed by physician for each medication)

Student Name: _____ DOB_____

Physician's Authorization of Medication for child to Self-Administer Medication

The above-named student has my authorization to carry and independently self-administer the following medication. I am requesting that this student be allowed to carry and self-administer this medication due to the life threatening circumstances that could result if this student does not have immediate access to this medication. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision.

Name of Medication:	
Dosage:	
Time and Route:	
Side Effects:	
Reason for Medication:	
Conditions Under Which Medication Is To Be Used:	

Physician Name: (please print)	
Physician Signature:	
Date Signed:	
Physician Address:	
Physician Phone:	

IMPORTANT NOTE**: All medication must be in the container in which it was purchased with the pharmacy label that includes dosage, instructions, and the prescribing physician's name. The medication must be prescribed for the student to whom it will be administered.* ***No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.

Parent/Guardian Authorization for Independent Self-Administration of Medication

I am the legal guardian of the above-named student. I confirm that the student has been instructed by his/her physician on the proper use of this medication and I approve of my son or daughter's independent self-medication as directed on this form. I also approve of Point Arena assisting with the administration of medication, as needed, while at school to him/her as directed by the physician's instructions. I give permission for the school administrator, agency nurse, or other designated school personnel, to consult with the above-named physician regarding any questions about this Authorization. My child has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally and behaviorally capable to assume this responsibility. If he/she has use of an auto-injectable epinephrine, he/she understands that he/she needs to alert any adult that 911 needs to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult and seek attention from an appropriate on-site first aide responder.

_____ _____
Parent/Guardian's Signature Date

_____
Parent/Guardian's Printed Name

REVIEWED AND APPROVED

_____ _____
School Nurse's Signature Date

Exhibit Adopted: **ARENA UNION ELEMENTARY/POINT ARENA JT. UHSD**
December 7, 2016 **Point Arena, California**

IMPORTANT: THIS AUTHORIZATION FORM MUST BE DELIVERED IN PERSON BY THE PARENT OR FAXED. TELEPHONED, STUDENT-DELIVERED OR EMAILED AUTHORIZATIONS WILL NOT BE ACCEPTED. ***NO EXCEPTIONS.***