SOUTHGATE COMMUNITY SCHOOLS

Medication Authorization Form-Physician/Parent Signature for Self-Administration/Self Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without 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 office in case the student runs out of or forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. The student must carry a copy of this form at school in order to carry their medication. Building administrators and appropriate teachers are informed on a need-to- know basis that the student is permitted to self-possess/self-administer medication.

Student Name:_____Birthdate:_____School Year:_____Start date:_____Stop date:____

To be completed by physician:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

*Route~oral(pill/capsule/chewable/liquid)~inhaled(inhaler, nebulizer)~topical skin application~topical(eyedrop, ointment)~topical ear drop~other (list)

List minimal frequency between doses (especially if p.r.n.):_____

If p.r.n.(as needed), list symptoms/conditions under which medication is to be given:_____

The student is capable of _____self-administering _____self-possessing the above mediaction(s)

_____ _____ _____

Physician Signature Date Physician Printed Name

Physician Phone:_____Fax:_____Address:_____

To be completed by parent/guardian:

I request and give permission for my child_____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.

_____ _____

Parent/guardian Signature Date