Authorization to Self-Carry/Self-Administer Medication

Name:____ Birth date:__________
(last) (first) (middle)

School:____ Grade: _____________

When a prescribing health professional, parent/guardian, student and nurse at school agree that self-carry/self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school.

Orders must be renewed annually or whenever medication, dosage, or administration changes.

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that _________________________ is capable of self-carrying self-administering the following medication:

____
Medication Route Dose Frequency

____
Medication Route Dose Frequency

I recommend self-administration of this medication for the treatment of: _______________________________

Comments: ____

____

Discontinuation date: _________________

Physician's Signature: ____ Date: ___________________

Printed Name: ____ Phone: __________________

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for my child to **self-carry** **self-administer** medication at school as prescribed by my child's physician and I authorize reciprocal release of information related to the medication between the school nurse and the physician/clinic. The information I provide will be shared only with staff in the school whose jobs require access to this information to ensure my child's safety and school success.

Signature of Parent/Guardian_____________________________________ Date: ______________

Daytime Phone Number: ____________________ Cell/pager number: _______________________

Email completed form to **tiffanyb@zmsch.k12.mn.us**
OR send to ZM Schools, 705 Mill St., Zumbrota, MN 55992