River Falls School District

SELF - ADMINISTRATION

PRESCRIPTION MEDICATION AUTHORIZATION FORM

When a practitioner and parent/guardian agree that self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately.

1. This form must be completed by a practitioner and student's parent/guardian.
2. The prescription medications need to be in its original pharmacy-labeled package: and package specifies the name of the student, the name of the prescriber, the name of the prescription drug, the dose, the effective date, and the directions in a legible format.
3. This form needs to be renewed each school year or whenever medication, dosage, or administration changes.

To Be Completed by Practitioner

I believe that _____ is capable of self-administering the
(Student's Name)

following medication:

Medication _____ Dosage_____

Route of administration_____ Frequency_____

I recommend self-administration of this medication for the treatment of _____

- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use the medication.
- Student may self-administer the medication.

Practitioner's signature_____ Date_____

Print Name_____

Address_____ Phone_____

To be completed by Parent/Guardian

I hereby give permission for my child to self-administer medication at school as prescribed by the practitioner. I will keep the school district aware of any changes in medication profile or health concern of my child. I give my medical provider and River Falls School District permission to release and obtain information from each other as necessary.

Parent/Guardian Signature_____ Date_____

"Practitioner" means any physician, dentist, optometrist, physician assistant, advanced nurse prescriber, or podiatrist licensed in any state.