

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.

<u>To Be Completed by Practitioner</u>
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 _____
<ul style="list-style-type: none">• 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 _____
<u>To be completed by Parent/Guardian</u>
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.