MEDICATION ADMINISTRATION FORM
AUTHORIZATION FOR STUDENT TO SELF-MEDICATE

Child's Last Name	First Name	Middle Name	Date of Birth (*Month/Day/Year)*

Diaganosis: _____

Medication: _____Preparation/Concentration:_____Dose: _____ Route:_____

For additional medications, pleae attach schedule including names, doses, routes and times.

Choose all options that are appropriate:

□ **Student** may carry medication & may self administer (**PARENT MUST INITIAL BELOW)**

□ Store medication in medical room & **student** to self-administer with superivsion (**PARENT MUST INITIAL BELOW)**

□ Store medication in medical room and nurse to administer.

□ **Student** to carry & self-administer on school trips and/or after school programs. (**PARENT MUST INITIAL BELOW)**

In School Instrctions

□ Standing daily dose: at __:__ AM/PM and __:__ AM/PM **AND/OR** PRN _____

Specify signs, symptoms or situations

□ Time Interval: q _ _ minutes or q _ _ hours as needed □ If no improvement, repeat in _ _ minutes or _ _ hours for a maximum of __ times

Conditions under which medication should not be given:

Home Medications (include over the counter)

Health Care Practioner *(please print)*	**Signature**	**Date**
Address	Telephone	

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-albuterol inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name. date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I further understand that I must immediately advise the school nurse and the principal and/or his designee(s) of any change in the prescription of instructions stated above.

**** SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications.**

____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage, and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize Ma'ayanot, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition I agree to provide "back up" medication in a clearly labeled container to be kept in the event my child does not have sufficient medication to administer.

____ I also authorize the school nurse, principal and /or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

Parent/Guardian's Signature	**Print Parent/Guardian's Name**	**Date**