Medication Prescriber/Parent Authorization Form for Self-Possession and Self-Administration of Medication

Self-possession gives the student permission (under the direction of the physician), to carry medication on his/her person for immediate administration. Self-administration gives the student permission to administer the medication (self-determined) in a manner directed by the physician without additional direction or supervision by school staff. **The school district recommends that spare medication, properly labeled in its original container, be kept in the clinic/office.** The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. If the student is found to be improperly using the medication, the student's physician and parent will be contacted regarding future self-possession. Medication authorization must be renewed annually or as needed.

Student Name: ______________________ Birth date: __________ Diagnosis: ______________________

TO BE COMPLETED BY LICENSED PRESCRIBER:

	Medication Name	Dose	Route	Time	Side Effects	Special Requirements
1						
2						

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

If p.r.n., list symptoms/conditions under which medication is to be given: ______________________

The student is capable of **Self-administering** AND/OR **Self-possessing** the above medication(s) **(CHECK ALL THAT APPLY)**

______________________ __________ ______________________

Physician's Signature Date Physician's Printed Name

TO BE COMPLETED BY PARENT:

I request and give permission for my child (named above) to **Self-Administer** AND/OR **Self-Possess** the above medication(s),according to district policy

______________________ __________

Parent/Guardian Signature Date

EXCHANGE OF HEALTH INFORMATION/RECORDS between Grand Ledge Public Schools & provider listed below

PURPOSE: Health assessment and planning for healthcare services and treatment in school, medical evaluation and treatment

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district may not be protected by the HIPAA Privacy Rule but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's care at school.

Name of School: __________________ Address: ______________________ Phone Number: __________

Physician's Name: __________________ Address: ______________________ Phone Number: __________

______________________ __________

Parent/Guardian Signature Date