KALAMAZOO AREA MATHEMATICS & SCIENCE CENTER

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM FOR SELF-ADMINISTRATION/SELF-POSSESSION

Please include all medications/medical conditions on this form, even IF the student only takes the medication at home. This form is used for prescribed medication as well as over-the-counter medication; if it will be taken at school, this form **ALWAYS needs a physician's signature.

I. To be completed by physician/licensed prescriber:

Student Name: _____ Date of Birth: _____ School Year: _____

Medication Name	Dose	Taken Only at Home?	Medical Condition	Time to be given/Frequency	Form/Route*	Common Side Effects/Adverse Reactions	Start/Stop Dates

*Routes: Oral (pill/capsule/chewable/liquid), inhaled (inhaler, nebulizer), topical (eye drop, ear drop, ointment), injection, other

List minimal frequency between doses (especially if PRN): _____

If PRN, list symptoms/conditions under which medication is to be given: _____

Please note any other medical conditions that may not require medication: _____

The above named student is capable of self-administering and self-carrying the above named medication(s).

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original container, be kept in the office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian.

_____ _____ _____

Physician's Signature | Date | Physician's Printed Name

II. To be completed by parent/guardian:

I request and give permission for my child _____ to carry and use his/her medication(s) (listed above) himself/herself. School staff members have my permission to share information with the physician and/or the physician's staff as needed to assist my child with medication needs.

_____ _____ _____

Parent/Guardian Signature | Date | Parent/Guardian Printed Name