THE CONNECTION SCHOOL
of Houston

STUDENT SELF-MEDICATION AUTHORIZATION

Parents, please have prescribing physician complete this form

Prescriber's Authorization

Student's Name: _____ Sex: _____

Date of Birth: _____/_____/_____ Grade: _____ School Year: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time(s) of day to administer: _____

Is this a PRN, (As-needed) Medication? ☐ YES ☐ NO

Medication shall be administered from: _____/_____/_____ to _____/_____/_____

The student has demonstrated that they are capable of self-administering their medication:

☐ YES☐ NO If no, then please explain: _____

Prescriber's Name: _____ Telephone: _____

Address: _____

Prescriber's Signature: _____ Date: _____

Parent / Guardian Authorization

I request that school health staff allow my child to self-carry with the intention to self-administer the medication described above by my child's primary prescriber. I agree to notify the school nurse or school health staff and provide a new self-medication authorization form when there is a change in my child's medication, health status, or authorized healthcare provider.

Describe how your child will carry/store their medications: _____

_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Authorization

Self-Administration Evaluation Date: _____/_____/_____

The student is capable of self-administration: ☐ YES ☐ NO

If no, then please explain: _____

☐ Teachers aware of policy/condition

☐ Medication location storage bag easily identifiable with name, condition, response details.

School Nurse Signature: _____ Date: _____