Osseo Area Schools, ISD 279

Self-Administration of Medication Authorization

To be completed yearly by prescribing health professionals for emergency mediations:

I believe that _____ (student name) is knowledgeable about the following medication and capable of self-administering it.

_____

Medication Dose Frequency Route

Medical Condition/Comments _____

_____ _____ _____ _____

Signature of Physician/Licensed Prescriber Print Name Phone Date

To be completed by parent/guardian:

I hereby give permission for my student to self-administer medication at school as prescribed by my student's prescribing health professional and I authorize reciprocal release of information related to the medication between the health service specialist and the prescribing health professional.

_____ _____

Signature of Parent/Guardian Date

To be completed by student and health service specialist:

Student agrees to:

- Follow his/her prescribing health professional's orders and review this plan with the Health Service Specialist.
- Use correct medication administration technique.
- Not allow anyone else to use his/her medication.
- Keep spare medication in the health office. (recommended)
- Notify the health office if:
  - symptoms continue or get worse after taking the medication.
  - student experiences side effects from the medication.
- Other_____

_____ _____ _____

Signature of Student Signature of Health Specialist Date

10/30/01