Rockford Public Schools
Quality Community – Quality Schools
Together Building a Tradition of Excellence

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Medication Authorization Form
for Self-Administration/Self-Possession of Emergency Medication

Self-administration means that the student can administer the emergency medication(s) 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, accompanied by an emergency action plan, the student may carry emergency medication on his/her person to allow for immediate and self-determined administration. The school district recommends that spare emergency medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out or forgets the emergency medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian.

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

To be completed by physician/licensed prescriber:

Start: ☐ Date form received Other dates: _____
Stop: ☐ End of school year Other date/duration: _____

Medication Name	Dose	Time to be Given	Form/Route	Side Effects	Adverse Reaction(s)

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

If p.r.n., list symptom(s)/condition(s) under which medication is to be given: _____

_____

The student is capable of ☐ **self-administering** ☐ **self-possessing** the above medication(s)

_____ _____ _____

Physician's signature Date Physician's Printed Name

Physician's Phone #: _____ Fax #: _____

Address: _____

To be completed by parent/guardian:

I request and give permission for my child (named above) to: ☐ **self-administer** ☐ **self-possess** the above medication according to school district policy and for the physician staff and school staff to share information regarding my child's health and medication needs.

_____ _____ _____

Parent/Guardian Signature **Printed name** **Date**

To be completed by student:

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original, properly labeled prescriptive/over the counter container.
3. Take medication only at the prescribed time/frequency and dose.
4. Keep a copy of this form and back up medication in the school office/clinic.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardians, and the privilege(s) of self-administration/self-possession denied.

_____ _____

Student Signature Date