

**AUTHORIZATION TO ASSIST COMPETENT STUDENTS
WITH SELF-ADMINISTRATION OF MEDICATION**

Dear Parent(s),

The self-administration of prescription medication by students can only be done if you understand the information below, provide your physician's authorization, and your written consent. Thank you for your cooperation.

1. Prescription medication can only be self-administered at school when it is required to maintain the health of the student.
2. Medication must be brought to school by parent/guardian, for the student for whom it was prescribed. It must be in the original container, exactly matching the physician's order, and labeled by the pharmacy to include the following:
 - a. Name of student
 - b. Name of physician
 - c. Name of medicine
 - d. Instructions as to dosage, amounts, exact time, and route.
3. No more than a week supply should be brought to school. A student is allowed to carry a metered dose inhaler with them to have it readily accessible for self administration.
4. The first dose of medication will be given at home in case of an adverse reaction to the medication.

Student's Name	School	Grade	Date of Birth	Medication Allergies
Name of Medication	Dosage and Route	To be administered at _____ Time		

PARENT/GUARDIAN PERMISSION:

I acknowledge that the above named student is competent to self administer this medication with the assistance from the nurse or designated school employee while in attendance at school. I give permission for my child to self-administer this medication with the supervision of a designated school employee. I grant the school nurse permission as necessary to discuss the prescribed medication with the below named physician. I agree to hold Williamson County Board of Education harmless for the administration of such medication. **I give permission for my health care provider and Williamson County Schools to send or receive a fax of this medical record.**

Name of parent/guardian	Home #	Work #
Signature of parent or guardian	Date	

REQUIRED FOR PRESCRIPTION MEDICATIONS ADMINISTERED MORE THAN ONE WEEK

PHYSICIAN'S AUTHORIZATION FOR SELF ADMINISTRATION (To be completed by physician)

The above named student is under my medical supervision.
 Reason for medication to be administered at school: _____
 Possible reactions/side effects: _____
 Special instructions for storage/handling: _____
 Child may carry Inhaler on self or in book bag _____

Name of Physician: _____ *Date prescription expires* _____

Signature of Physician	Title	Date
Address	Phone #	Fax #