Jefferson County School District 509J
UNITE. ENGAGE. SOAR.

AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION
By Student

School_____

1.	**Legal First Name**	**Legal Last Name**	
	Birth Date	**Grade**	**Teacher's name (for K-5 students)**
	Month Day Year		

Please read the following statements and provide your initials as an approval or acknowledgement. Student may complete if 15 years of age or older.

2. **All medication must be in its newest original container with accurate labeling.** _____ Initials

3. Parent/Guardian or Student is responsible for providing needed medication, maintaining the supply, and keeping it away from other students. _____ Initials

4. Student must be developmentally and behaviorally competent to self-administer medication and medication must be required for the student to remain at school. _____ Initials

5. Parent/Guardian or Student accepts responsibility of notifying the school nurse or the school's main office staff **in writing** of any changes to the student's medication during the school year and after the date shown on this document. Changes to the prescription label or container directions must be in writing from the healthcare provider. _____ Initials

6.	**Medication Name**		**Type**			**If the medication is prescription, please provide the RX number**	
			☐ Non-prescription ☐ Prescription *Admin approval required. RN approval required for Rx only.				
	Start Date		**End Date**			**Time of Day to be Administrated**	
	Month Day Year		Month Day Year				
	Dose	**Frequency (how often)**	**Route**				
			☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Inj.				
	Reason for Medication		**Special Instructions**				

7. **Parent/Guardian or Student Signature (if 15 years of age and older) of Authorization**

I verify that the above health information is accurate and complete, and I understand that it is my responsibility to notify the school office in writing promptly of changes to this information. This authorization applies only to the medication listed above and the duration of treatment or school year. This authorization provides permission to exchange information, as necessary, between the school nurse, school staff, and/or student's health provider.

Parent/Guardian or Student Signature: _____ **Date:** _____

Parent/Guardian or Student Printed Name: **Telephone:**

8. **Physician Direction** *For any non-prescription medication that is non-FDA approved*

I understand that the above medication is not FDA approved and therefore requires this written and signed order from an approved provider. My signature affirms that this medication is necessary for the above-mentioned student to remain at school.

Provider Name (printed): _____ **Date:** _____

Provider Signature (or stamp): **Telephone:**