Over the Counter Pain Medications

Self-Administration of Medication Authorizations

Parent/Guardians Request and Authorization for Self-Administration

I request and authorize my child _____ to carry and/or self-administer
(Insert name of student) (circle one or both options)

his/her medication _____.
(insert name of medication)

Medication is permitted in accordance with district policy and procedure(s). Student name must appear on the **original** medication container.

Responsibilities for carrying medication:

Yes **No**

[ ] [ ] The student can demonstrate correct use/administration.
[ ] [ ] The student recognizes proper and prescribed timing for medication.
[ ] [ ] The student agrees to not share medication with others.
[ ] [ ] The student will keep the medication in an agreed upon location(s)

*(please indicate location)*_____

[ ] [ ] The student will keep a second labeled container in the health office.
(Optional, based on district policy and procedure(s)).

The student [ ] is [ ] is not able to demonstrate the specified responsibilities.

[ ] Yes [ ] No The student may carry the medication unless and until he/she fails to follow the above agreement.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Student Date