



Appleton Area School District

HEALTH SERVICES * P.O. Box 2019, Appleton, WI 54911 * 920-997-1399 ext. 2106

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATIONS IN THE SCHOOL SETTING

Note: Return the completed form to the main office.

School FAX #: _____

One form for each medication given at school.

Student's Name: _____ Birthdate: ____/____/____

School: _____ Grade/Room _____ Teacher _____

Medication Name/Strength: _____ Prescribed* Non-Prescribed

Dosage: _____ How Given: _____ Time to be Given: _____
(in mg, ml, etc.)

Dates Effective (check one): School Year _____ **OR** Specific Dates: _____ to _____

Reason for Medication/Diagnosis: _____

If "as needed," list conditions under which medication should be given: _____

Possible side effects: _____

FOR COMPLETION BY PARENT (Required for all prescription and non-prescription medications)

Is the child authorized to carry and self-administer medication? Yes No

As the parent of the above named student, I ask that my child be permitted to self-medicate as authorized by myself and the prescribing practitioner. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers and to contact the child's practitioner if necessary.

Parent/Guardian Signature: _____ Date: _____

***FOR COMPLETION BY PRESCRIBING PRACTITIONER** (REQUIRED for all prescription, non-FDA approved or medication dosages exceeding typical recommendations)

Prescribing Practitioner's Name: _____

Telephone Number: _____ Fax Number: _____

Is the child knowledgeable about his or her medication? Yes No

Has the child demonstrated the proper technique in administering medication? Yes No

If needed, how soon can administration of medication be repeated? _____

I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

It is my professional opinion that _____ should **not** carry and administer his/her medication by him/herself.

*Prescribing Practitioner's Signature: _____ Date: _____