**PRESCRIPTION MEDICATION FORM**

CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name Date of Birth

|  |  |  |  |
| --- | --- | --- | --- |
| *To be filled by prescriber:*  **Medication**  (name/dosage/route/frequency) | *To be filled by prescriber:*  **Diagnosis** | **Prescriber Consent for Self-Administration** | **Parental Consent for Self-Administration** |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |
|  |  | YES NO | YES NO |

**Physician/Prescriber:** *Please complete the first three columns & sign below.*

Signature: Printed Name:

Address:

Phone #: Fax #: Date:

**Parent/Guardian:** *Please complete the last column & sign below.*

Signature: Printed Name: Date:

* Each prescription medication requires parent/guardian and provider consent for self-administration privileges.
* School policy does not allow controlled medication to be self-administered.
* Over the counter medication does not need to be added to this form.