Whittemore-Prescott Area Schools
Self-Administered Medication Authorization Form

According to P.A. 10 of 2000, a student may possess and use at school a metered dose inhaler or a dry powder inhaler for the relief of asthma symptoms. Self-administration means that the student can administer the inhaler in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on her/his person to allow for immediate and self-determined administration. Spare inhaler medication, with prescription label, may be kept in the office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon notice to the parent/guardian

Student Name:_____Date of birth___/____/ _____School Year_____

I. To be completed by Physician/Licensed Prescriber

	Medication Name/Indications	Dose	Time to be Given/Frequency	**CommonSide Effects/ Adverse Reactions**	**Start/Stop Dates**
1.					
2.					

List minimal frequency between doses (especially if PRN) _____

If PRN list symptoms, conditions, under which medication is to be given: _____

Special Instructions:

_____

_____

_____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

(_____) (_____) _____ _____
Physician's Phone Physician's Fax Physician's Address

Over

II. To be completed by Parent/Guardian: I request and give permission for my child _____to receive the above medication(s) at school according to school district policy. I give consent for the school district staff to share information with the physician and/or the physician's staff as needed to assist my child with medication needs.

_____ _____

Parent/Guardian Signature Date

Student Name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled/over-the-counter container
3. Take medication only at the prescribed time/frequency and dose
4. Carry a copy of this form with me and present it to school staff if asked

I am knowledgeable regarding the dose, desired effects, side effects, administrations, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege(s) of self-administration/self-possession denied.

Signature: _____ Date: _____