

**Smithton R-VI School District  
Self-Administration of Medication Record**

School Year \_\_\_\_\_

Students may carry and self-administer a daily dose of over-the-counter or prescription medication if a parent's written request on the authorization below is on file in the nurse's office. The medication must be in the original container.

Prescription medication that is to be taken for 2 weeks or less may be carried and self-administered by the student if arrangements are made in advance with the nurse. Only a daily dose may be carried and the medication must be in the pharmacy labeled container and prescribed to the student. Prescription medication taken on a daily basis for longer than 2 weeks will be kept in the nurse's office.

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Medication \_\_\_\_\_ mg Dose \_\_\_\_\_ Times \_\_\_\_\_

For treatment of \_\_\_\_\_ Date to begin \_\_\_\_\_ Date to end \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician Phone # \_\_\_\_\_

Pharmacy \_\_\_\_\_ Rx # \_\_\_\_\_

My child will be responsible for carrying and self-administering this medication. My child agrees to follow the school district's policy and procedure for carrying and self-administering medication. Failure to comply with the district's procedures will result in the loss of the privilege of carrying medication and may result in disciplinary action.

**School personnel do not provide over-the-counter(OTC) medication for students at any time.** All OTC medication must be provided by the parent or guardian.

Medication must be used in accordance with \_\_\_\_\_ School District Policy.

Parent/guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parents home phone \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

The student must be able to state the name of the medication, correct dose, symptoms requiring medication, and correct timing of medication. Student agrees/understands they will not share medication with others and will keep medication in his/her personal belongings at all times.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Student **does/does** not demonstrate meeting the requirements for carrying/self-administering this medication.

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_