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/GUARDIAN *(Required for all prescription and non-prescription medications)*
Is the child authorized to carry and self-administer medication? ☐ Yes ☐ No

As the parent/guardian 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 PRACTITONER** *(REQUIRED for all **prescription medications or medication dosages exceeding typical recommendations. Per AASD medication policy, non FDA-approved medications cannot be administered.**)*
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:_____