# Tallapoosa County Schools

## Medication Self-Administration Documentation and/or Medication Authorized to Keep On Person Documentation

Student Name_____ Grade _____

Name of Medication _____ School _____

- ✓ Standardized Medication Authorization is complete with parent and prescriber affirmation signatures authorizing this student to self administer medication and keep his/her medication on person.
- ✓ Students Individual Health Care Plan is complete

_____ Parent/Prescriber Authorization matches prescription label and the label is intact.

_____ Medication is not expired: Product manufacturer expiration date _____

_____ Student has knowledge of medication administration and safety, including information addressed in his/her HCP.

_____ Student demonstrates knowledge, skill and experience of his/her chronic illness and medication. He/She verbalizes potential side effects and adverse reactions including when to contact the school nurse or prescriber.

### Parent Prescriber Authorization for Self Administration of Medication:

_____ Student agrees he/she is accountable for safe and appropriate self administration of the authorized medication. He/ She has been informed of legal policies and requirements related to self administration of authorized medication and will not give or share medication with another person.

### Parent Prescriber Authorization for Medication to Keep on Person:

_____ Student agrees he/she is accountable for safe and appropriate possession of the authorized medication. He/ She has been informed of legal policies and requirements related to possession of authorized medication and will not give or share medication with another person.

**Parent/Guardian Signature _____ Date: _____**

**Student Signature _____ Date: _____**

*Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.*

**Nurse Signature: _____ Date: _____**