Elgin School
(520) 455-5514
23 Elgin Rd, Elgin, AZ 85611

REQUEST FOR SELF ADMINISTRATION OF MEDICATION AT SCHOOL

School Year: _____

Name:_____ School: _____

Grade:_____Teacher: _____

Medication: _____ Dosage: _____ Reason: _____

Time to Be Given:_____ ❑ AM ❑ PM or ❑ As Needed

From (Date)_____To (Date) _____

Prescriber's Name:_____Prescriber's Phone #: _____

Known Drug or Food Allergy to: _____

- Prescription medication must be in the original container as prepared by a pharmacist and labeled, including the patient name, name of medication, dosage, and time to be given. An over-the-counter medication must be in the original packaging, with all directions, dosages, compound contents, and proportions clearly marked.
- A signed physician's statement indicating the necessity must accompany and request for self-administration of medicine, whether it is prescription or over-the-counter medicine except in the case of medication for diagnosed anaphylaxis including auto-injectable epinephrine and breathing disorders requiring handheld inhaler devices. In these cases the student's name on the prescription label is sufficient for the physician's recommendation.
- Student misuse of medication being self-administered may result in seizure and disciplinary action.
- A back up of the medication is advised to be kept in the health office in the event your child does not have theirs available.
- This request is for the current school year only.

I hereby request and give my consent for my child to carry and self-administer the above medication according to the health provider's directions. This request includes authorization for the school nurse to contact the health care prescriber when necessary. I agree to notify the school nurse immediately in writing of any change in medication, dose, or time of day for the administration.

Parent/Guardian Signature:_____Date: _____

Self Carry Medication:
Medication Count:____ Exp.Date:____Parent Signature:_____ Nurse/Designated Staff Signature: _____ Date:_____

Office Backup Medication:
Medication Count:____ Exp.Date:____Parent Signature:_____ Nurse/Designated Staff Signature: _____ Date:_____

Physician's Statement of Necessity for Self-Administration of Medication

(Not required for auto-injectable epinephrine or handheld inhalers)

Attach a written recommendation or sign the statement below:

Students Name:_____is knowledgeable about the medication I have prescribed. He/she understands the purpose, appropriate frequency, and has demonstrated the correct use of the prescribed medication. I recommend this student keep the prescribed medication on his/her person to self-administer while at school.

Signature of Health Provider: _____ Date: _____