Neighborhood House Charter School– Self Medication Administration Form

Parent/Guardian Authorization for Prescription Self Medication Administration

Student:____________________________________DOB:____________Grade:_____

Diagnosis:____

Medication/Dosage:____

Frequency:____

Time or circumstances when medication is given:______________________________

____

Side Effects:____

Parent/Guardian: Name(printed):____

Telephone Numbers:
Home:__________________Cell:____________________

Work:__________________Alt:____________________

Emergency:_____________________________________

Other person(s) to be notified in case of medication emergency:

Name:____

Home:__________________Cell:____________________

Work:__________________Alt:____________________

Parent Agreement: I agree with the plan to allow my child to self-medicate as outlined above.

____ Date: ____/____/____

Parent Signature

( ) Teacher Training Completed
( ) Student Demonstrates Understanding
( ) Storage Area Secure
( ) Standard Medication Protocol in Place

School Nurse:______________________________Date:____/____/____