Please return to
HERITAGE CHRISTIAN ACADEMY
Email: nurse@heritagechristianacademymn.org Fax: 763-463-2293

Self-Administration of Medication Authorization

To be completed yearly by prescribing health professionals for emergency mediations:

I believe that _____ (student name) is knowledgeable about the following medication and capable of self-administering it.

Medication	Dose	Frequency	Route

Medical Condition/Comments _____

Signature of Physician/Licensed Prescriber	Print Name	Phone	Date

To be completed by parent/guardian:

I hereby give permission for my student to self-administer medication at school as prescribed by my student's prescribing health professional and I authorize reciprocal release of information related to the medication between the health service specialist and the prescribing health professional.

Signature of Parent/Guardian	Date

To be completed by student and health service specialist:

Student agrees to:

- Follow his/her prescribing health professional's orders and review this plan with the Health Service Specialist.
- Use correct medication administration technique.
- Not allow anyone else to use his/her medication.
- Keep spare medication in the health office. (recommended)
- Notify the health office if:
  - symptoms continue or get worse after taking the medication.
  - student experiences side effects from the medication.
- Other_____

Signature of Student	Signature of Health Specialist	Date

10/30/01