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 medications:

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

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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:

Students agree to:

- Follow his/her prescribing health professional's orders and review this plan with the Health Service Specialist.
- Use correct medication administration techniques.
- 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 medication.
    - Student experience side effects from the medication.

- Other _____

_____ _____ _____
Signature of Student Signature of Health Specialist Date