

2018/2019

**OVERNIGHT SCHOOL SPONSORED ACTIVITIES ONLY**

Self-Administration of Medication Authorization Form

Grades 9-12



Serving age 18-months through Grade 12

13500 Layhill Road, Silver Spring, MD 20906

301-576-2800 fax: 301-576-2805 [www.barrie.org](http://www.barrie.org)

This form must be completed fully and on file in the health office in order for a student to self-administer medication(s) during school sponsored **OVERNIGHT** activities, including Extended Study Week (ESW). This form is required for each medication.

- All prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the unopened original container with the label intact.

The School Nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the student and/or the student’s medication(s).

**Prescriber’s Authorization**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_

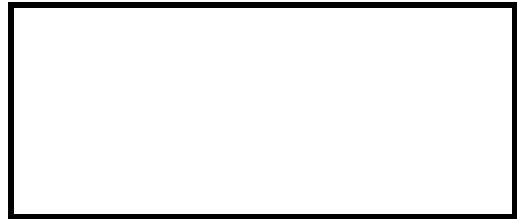
Relevant side effects:      None expected      Specify: \_\_\_\_\_

Medications shall be administered from: \_\_\_\_\_ to: \_\_\_\_\_  
Month/Day/Year      Month/Day/Year

Prescriber’s Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_



Self-carry/self-administration of medication must be authorized by the prescriber and be approved by the School Nurse according to the Barrie School Medication Policy prior to medication administration.

Prescriber’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)      Month/Day/Year

**Parent/Guardian Authorization**

I/We request that our student self-administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including self-administration of medication. I/We authorize the School Nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Reviewed and approved by School Nurse:** \_\_\_\_\_  
Signature      Date