2021-2022

**OVERNIGHT SCHOOL SPONSORED ACTIVITIES ONLY**

Self-Administration of Medication Authorization Form

Grades 9-12

**13500 Layhill Road, Silver Spring, MD 20906**

**301-576-2800 fax: 301-576-2805**

**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 Barrie 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

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## 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 Barrie 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**