Pembroke High School

80 Learning Lane, Pembroke, MA 02359
Samantha.Knisley@pembrokek12.org
Alison.Viviano@pembrokek12.org

Samantha Knisley, RN, BSN, MBA
Alison Viviano, RN, BSN
(781) 293-9281 Ext. 2108
(781) 293-2812 FAX

Self-Administration Medication Authorization Form

Dear Parent/Guardian,

District/school policy allows students to self-administer medications with school nurse and parent/guardian approval. In order for your child to carry and self-administer their own medication(s), you must complete **Part A** of this form. **Part B** will be completed in the health office with your child. Your child must be able to answer the questions in Part B or they will not be permitted to self-administer medication(s).

A. To Be Completed By Parent/Guardian:

I hereby request that my child be permitted to carry on their person and self-administer the medication(s) listed within this document.

Student Name	Medications

My child has been instructed in and understands the purpose, appropriate method, frequency and use of their medication(s). My child understands that they are responsible and accountable for carrying and administering their medication(s).

I will be responsible to ensure my child has their appropriate medication(s) on hand and support my child in following the agreement in Part B.

Signature of Parent/Guardian	Date:

B. To Be Completed By The School Nurse:

Student is consistently able to **Name** the medication; **Identify** the correct medication; **Explain** the purpose of the medication; **Knows** the correct dosage; **Explain** when the medication is to be taken.	YES ☐ NO ☐
Student verbally demonstrates the correct use/administration.	YES ☐ NO ☐
Student realizes their responsibility in carrying their own medication(s) in properly labeled pharmacy or manufactured container(s) and agrees not to share the medication(s) with others.	YES ☐ NO ☐
Student agrees to notify the closest adult immediately after self-administering medication if experiencing any difficulties on school-sponsored trips.	YES ☐ NO ☐
Student understands that the privilege of carrying and administering their own medication(s) will be rescinded if they do not follow the above agreement.	YES ☐ NO ☐

Signature of Student	ID#	Date:

Approval: YES ☐ NO ☐	Signature of School Nurse	Date: