Virginia Public Schools ISD #706 Health Service
Phone: 218-742-3918 Roosevelt/ Virginia High School ____
218-742-3821 Parkview Learning Center ____
Fax: 741-8522

## AUTHORIZATION TO SELF-ADMINISTER & SELF-CARRY MEDICATION

Student Name:_____Birthdate: _____
Grade:_____ School Year:_____

Medical Diagnosis:_____
Reason for Medication at school: _____
Medication to be taken at school:

| MEDICATION | DOSE | TIME TO BE GIVEN |
|---|---|---|
| | | |
| | | |
| | | |

Other considerations/directions:_____

Is acceptable for student to carry medication on his/her person ____yes _____no. Is acceptable for student to self-administer directed: ____yes_____ no.

Start date:_____Stop date:_____(All authorizations expire at the end of the school year.)

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Physician/ Licensed Prescriber Signature Phone Number Date

_____

Licensed Prescriber/Health Care Facility Fax Number

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I request and authorize _____ to be responsible for his/her medication on his/her own person and to self-administer medication. I release school personnel from liability should inappropriate usage and/or reactions result from taking the medication(s). I understand all medications needs physician authorization and will be monitored by the school nurse.

**By signing this form parent/guardians provide authorization for their child's health care provider noted above via medical records to send medical forms/information via fax, phone, or mail directly to the ISD 706 Virginia MN Public School Nurse requesting information.**

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Parent/Legal Guardian Signature Relationship to Student Date