**Medication Administration Authorization Self-Administration/Self-Possession Form**

Michigan State Law requires that students self-administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian. **"Self-administration"** means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. **"Self-possession"** means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate administration.

* Medications must be prescribed in writing by a physician or other licensed prescriber and must be renewed at least annually.
* All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, dosage, route and time(s) to be given.
* Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
* Any misuse of medication by a student that violates school policies, including sharing medication for any reason, will result in revocation of self-possession privileges and may result in a referral to law enforcement officials.
* If your child is Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan.

STUDENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_**

SCHOOL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TEACHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE PHYSICIAN:**



Form of medication: ❑Tablet/capsule ❑Liquid ❑Inhaler ❑Injection ❑ Nebulizer ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special instructions/storage requirements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signs/Symptoms for which medication is being prescribed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Restrictions and/or side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Order Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Order End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student is capable of and authorized to:** ❑ self-administer the above medication ❑ self-possess the above medication

**NOTE:** To participate in Medicaid School Services Program, a valid prescription MUST be signed and dated by a physician or other licensed prescriber and include the prescriber’s name, address, telephone number, and NPI number.

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_ NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN:**

I hereby authorize trained school staff to administer the identified medication, ordered by the licensed prescriber, to the child above. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA. I will not hold the Board of Education or its personnel responsible for complications related to the medication.

Student is capable of and authorized to: ❑ self-administer the above medication ❑ self-possess the above medication

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT:** I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication. I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and the privilege(s) of self-administration/self-possession denied.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_