§1917.G ,H

Self-Administration Medication Authorization Form

My child, _____has my permission to self- administer the following medication to his/her self:

Medication Name*/Strength: _____

Dosage Amount/Frequency: _____

How to be Given: Oral Topical Other: _____

Time to be Given: _____

Date(s) to be Given: _____

Side Effects/ Anticipated Reactions: _____

_____

Special Instructions (If Applicable): _____

_____

_____ _____

Parent's Signature Date

If all information is not filled in completely, medication will not be given.

_____

Administration Documentation

Date Given	Time Given	Dosage Given	Signature of Person Administering Medication

_____

Signature of Staff Completing Form

**medication should be in its original container*