

**Self Administration Medication Authorization Form
Medicine Must Be In Its Original Container**

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, your child will not be allowed to self-medicate.**

Administration Documentation

Date Taken	Time Taken	Dosage Taken	Signature of Individual Witnessing the Self-Administering Medication

Signature of Staff Completing Form