HERITAGE ACADEMY
Maricopa • K - 5

Personal Over- The- Counter Medication Authorization Form

To be completed by scholar's Parent/Guardian

Scholar Name: _____ Date Prescribed: _____

Duration of Medication: _____

Diagnosis/Indications for Administration: _____

Medication (s): _____

Dose: _____ Route: _____

Daily Time of Administration/or PRN: _____ Frequency: _____

If PRN Describe Indication(s) for Administration: _____

Other Information: _____

Parent/Guardian Name: _____ Contact Number: _____

Parent/Guardian Signature: _____ Date: _____

Please attach Asthma Action Plan or Diabetes Plan if it applies

Authorization for Self-Administration of Medication During School Hours

(Epi-pen, Insulin/Insulin Pump, and/or Inhaler only)

I have instructed the scholar, named above on this card, in the use of his/her Epi-pen, Insulin, Insulin Pump, and/or Inhaler and he/she may self-administer medication as prescribed on the Prescription Authorization Form during school hours.

Health Care Provider Name: _____ Contact Number: _____

Health Care Provider Signature: _____ Date: _____

Parent/Guardian Request for self-administration of Epi-pen, Insulin/Insulin Pump, and/or Inhaler

This section must be completed and signed before the student will be permitted to self-administer medication. The Prescription Authorization Form must also be completed by the scholar's medical provider.

Please initial and sign below:

_____ I request that my child be permitted to self-administer his/her Epi-pen, Insulin Pump, Insulin, or inhaler at school, as authorized by his/her medical care provider on the Prescription Authorization Form.

Parent Signature: _____ Date: _____