COUNTRY CLASSROOM
Permission to Administer Medications 2023

Medication orders need to be renewed each camp year.

Name		**DOB**		**Age**	

TO BE COMPLETED BY HEALTH CARE PROVIDER

Diagnoses:

Medication Name	Dose	Route	Time	Self-Directed*	Self-Admin/ Self-Carry**

*Self-Directed: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

**Self-Administer/Self-Carry: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN

• I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature _____ Date _____ Phone _____

• Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by an adult. Parents assume responsibility for ensuring their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves irresponsible or incapable. To request this option, please sign below:

Parent/Guardian Signature _____ Date _____ Phone _____