Department of Catholic Schools Form 5910.2
Diocese of Wheeling-Charleston

Medication Authorization Form
Self-Administration of Medication

WV Statutes directs that students may be permitted to self-administer medication for asthma or other potentially life-threatening illnesses providing proper procedures are followed. This form must be completed annually for any student requiring self-administration of epinephrine (EPIPEN), insulin, or asthma inhalers while in school.

Student's Name: _____D.O.B._____ Grade: _____

School Name: _____

Section I- To be completed by the Licensed Health Care Provider

I hereby acknowledge that my patient, _____
has been diagnosed with
_____

Name of Medication(s) _____

Dosage: _____

Method of Administration:_____

Time and Frequency of Administration: _____

How soon may it be repeated? _____

Possible Side Effects: _____

Additional Instructions:
_____

This student has been instructed in the proper way to use and self-administer his/her own medication (s). He/she is knowledgeable and capable to identify medication, specific symptom/occurrences for the need of the medication, method, dosage and schedule of medication administration, state side effect/adverse reactions and knowledgeable of how to access assistance for self, if needed, in an emergency. It is my professional opinion that this student should be allowed to carry and use this medication by him/herself.

Effective for School Year: 20_____ to 20_____

_____ _____
Licensed Health Care Provider Signature Date

Section II- To be completed by parent/guardian

I authorize _____to permit my child to carry and self-administer his/her own medication as identified in Section I of this form.

The licensed health care provider has noted in Section I, that the student has asthma, allergies or another potentially life-threatening illness and has instructed the student in the proper method of self-administration with the medication(s) identified.

I acknowledge that _____shall incur no liability as a
(school name)
result of any injury arising from the self-administration of medication(s) by the student noted above.

I shall indemnify and hold harmless _____and its employees or
(school name)
agents against any claims arising out of the self-administration of medication by the student noted above.

I give permission for the information included on this form to be shared with the appropriate staff members, coachers, and transportation personnel for the safety and welfare of my child.

_____ _____

Parent/Guardian Signature Date