POLYTECHNIC SCHOOL
POLYSUMMER 2025
PRESCRIPTION MEDICATION AUTHORIZATION FORM

STUDENT LAST NAME	FIRST NAME	BIRTHDATE

Version 2.3

Prescription Medication Instructions
Complete in full the chart below including the name, strength, dosage, time schedule and reason for taking the medication(s)

IMPORTANT guidelines for self-carry and self-administer authorization

- Students may self-carry/self-administer the following prescription medication ONLY: **inhaled asthma medication, auto-injectable epinephrine, diabetes medication, birth control pills and topical acne medication**
- Give careful attention to student's age, grade level and ability to self-carry/self-administer medication safely and responsibly

Name of Prescription Medication	Strength	Dosage (e.g. 2 tabs)	Time(s) Taken	Reason	Medication is listed above as approved for self-carry/ self-administer	Able to self-carry? (circle one)	Able to self-administer? (circle one)
					☐ YES ☐ NO	YES NO	YES NO
					☐ YES ☐ NO	YES NO	YES NO
					☐ YES ☐ NO	YES NO	YES NO
					☐ YES ☐ NO	YES NO	YES NO
					☐ YES ☐ NO	YES NO	YES NO

I CONSENT for the school, through its employees or agents, to provide to the student the prescription medication indicated consistent with the instructions set out in the chart above. By checking the "YES" box indicated in the chart above, I request that the student self-carry and/or self-administer the above names school-authorized prescription medication during the summer school day and/or while attending summer school day trips. The student has received training, demonstrates proper technique and knows the proper and prescribed timing for the medication. The student will not share the medication with others. S/he agrees to follow the school procedures concerning the handling and administration of such medication.

X_____ **Date** _____
Parent/Guardian 1 Signature required

X_____ **Date** _____
Parent/Guardian 2 Signature required

X_____ **Date** _____
Physician Signature required

_____
Print Physician Name

Physician Stamp:

Student signature is required if s/he plans to self-carry/self-administer the named school-authorized prescription medication indicated in the chart above during the school day and/or while attending day and overnight school trips **Student Signature: X**_____ **Date:** _____