Self-Administration of Medication Authorization

When a prescribing health professional, parent/guardian, student, and school nurse agree that self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully, and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The medication must be brought to school in an original container appropriately labeled by a pharmacist or the prescribing health professional. A student who has demonstrated competencies may then be allowed to self-administer medication if he/she signs the agreement.

This form must be completed by the prescribing health professional and parent/guardian and returned to the school nurse. Orders must be renewed annually or whenever medication, dosage, or administration changes.

Student Name: _____ DOB: _____ Grade: _____ School Year: _____

School: _____ Phone: _____ Fax: _____

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I certify that _____ is capable of self-administering the following medication:

_____

Medication Dose Route Frequency

I recommend self-administration of this medication for the treatment of: _____

Start Date: _____ Stop Date: _____ **(must renew annually)**

_____ _____

Signature of Health Care Provider Clinic Name and Address

_____ _____ _____

Printed name of Health Care Provider Phone number Date

TO BE COMPLETED BY PARENT/GUARDIAN

I request and authorize my child _____ to carry and self-administer the above noted medication per the prescribing health professional.

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger themselves or others.
- I understand that if my child misuses medication, school staff may confiscate the medication.
- The school is released of any liability in the event that adverse reactions result from my child's self-administration of medication.

_____ _____ _____

Signature of Parent/Guardian Phone Number Date

SEE BACK FOR STUDENT AGREEMENT

Student Self-Carry/Self-Administration of Medication Agreement

Student Name: _____ Grade: _____ School: _____ Year: _____

Licensed Health Provider: _____ Clinic: _____

Medication (include strength): _____ Dose: _____ Frequency: _____

Medication is permitted in accordance with district policy and procedures. In addition to the parent/guardian, the student's licensed health provider must authorize self-carried/administered medication (see front).

Student Agreement

I agree to:

- Follow my prescribing health professional's orders
- Have been instructed in the proper method of administration of this medication and will use correct medication administration technique
- Not allow anyone else to use my medication
- Notify the school nurse under the following circumstances:
    - My symptoms continue or get worse after taking the medication
    - I suspect that I am experiencing side effects from this medication
    - Other: _____

_____ _____

Student Signature Date

Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Building Principal and Health Services Supervisor.

The student above is able to demonstrate the specified responsibilities. The student may carry the medication listed above unless and until he/she fails to follow the above agreement.

_____ _____

School Nurse Signature Date