SELF-ADMINISTRATION OF MEDICATION AGREEMENT

STUDENT:_____ DOB:_____GRADE/SCHOOL:_____

PARENT:_____ CELL PHONE:_____

When a prescribing health care provider, parent/guardian, student, and Licensed School Nurse (LSN) 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 care provider and written authorizations by the parent/guardian must be provided to the school. The medication must be brought to school in a container appropriately labeled by a pharmacist or the prescribing health care provider. The student must demonstrate competencies in self-administration of the medication and sign the agreements. Orders must be renewed annually or whenever medication, dosage, or administration changes.

To Be Completed By Prescribing Health Care Provider

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

_____

Medication *Route.* *Dose.* *Frequency*

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

Comments:_____

Discontinuation Date:_____

_____

Signature of Prescribing Health Care Provider *Clinic* *Date*

Parent/Guardian Agreement

- I hereby give my permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health care professional.
- I release school personnel from liability in the event adverse reactions result from taking the medication.
- I will notify the school of any changes in medication.

_____

Signature of Parent/Guardian *Date*

Student Agreement

I agree to:

- Follow my prescribing health care provider's order.
- Use correct medication technique.
- Maintain a written record of my medication administration at school.
- Not allow anyone else to use my medication.
- Keep a supply of medication with me in school and on field trips.
- Consult with the LSN: Weekly Monthly Other:_____
- Notify the LSN if the following occurs:
    - My symptoms continue or get worse after taking my medication.
    - I suspect that I am experiencing side effects from my medication.
    - Other:_____

_____

Signature of Student *Date*

This student has demonstrated knowledge about and proper us of their medication.

_____

Signature of Licensed School Nurse *Date*