School Year: _____

AUTHORIZATION TO SELF-CARRY/SELF-ADMINISTER MEDICATION

Prescription asthma, epinephrine auto-injectors and other emergency medications.

TO BE RENEWED EACH SCHOOL YEAR

To be completed by Prescribing Health Professional

I believe that _____ is capable of self-carrying/self/administering the following medication(s):

Note: only the following prescription medications are allowed for student self-carry/administer – prescription asthma medications, prescription epinephrine, and/or other necessary emergency medications.

Medication	Route	Dose	Frequency
Medication	Route	Dose	Frequency

I recommend self-carrying and self-administration of this medication(s) for the treatment of:

_____

_____

_____

Comments: _____

_____

_____

Discontinuation date: _____

Nurse Signature: _____

Printed Name: _____ _____ Phone _____ Date

To be completed by Parent/Guardian

I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication(s). I understand that if my child misuses by not takin the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-carry/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 professional/clinic.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Work phone number or other daytime phone number Phone

Please complete reverse side →

To be completed by Student – Student Agreement

Medication is permitted in accordance with district policy and procedures. In addition to the parent/guardian, the student's licensed prescriber must authorize self-carry and self-administration of medication(s). Student name must appear on the medication container, inhaler and/or injector.

I,_____agree to the responsibilities of carrying medication(s)

Follow my health care provider's orders and Emergency Care Plan

Recognize correct dosage and proper timing for medication

Refill my prescriptions before they expire (or remind my parent/guardian to do so)

Use correct medication administration technique (demonstrate to nurse)

Not allow anyone else to use my medication

Keep a current supply of my medication, located:

Notify the school nurse or_____under the following circumstances:

Questions or concerns regarding medication

Suspect that I am experiencing side effects from the medication and/or am having an allergic reaction

Symptoms continue to get worse after taking my medication

_____ _____

Signature of Student Date

To be completed by Licensed School Nurse/Health Associate

☐ This student has demonstrated mastery related to his/her medication and self-carrying skills

☐ This student needs reinforcement of his/her medication and self carrying-skills

☐ The student is / is not able (circle) to demonstrate the specific responsibilities related to self-carrying and self-administration of medication(s).

☐ The student may carry the medication(s) unless and until he/she fails to follow the above agreement.

_____ _____

Signature of Nurse/Health Associate Date

NOTE: Health Services will assess the student's competencies to self-carry and/or self-administer medication and if there are concerns, will contact the health care provider and parent to discuss further options. If agreement is not reached, the parents may contact the District Health Coordinator or School Administrator. Permission for self-carry/self-administration may be suspended if the student is unable to follow the above procedure.

STJ