WABASHA-KELLOGG SCHOOLS School Year:_____
STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

When a prescribing health professional, parent/guardian, student and nurse at the school agree that self-administration of a medication is appropriate for the 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 the school by the parent / guardian in a container appropriately labeled by a pharmacist or the prescribing health professional.

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

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TO BE COMPLETED BY THE PRESCRIBING HEALTH PROFESSIONAL

I believe that _____ is capable of self-administering the following medication:
(Student's name)

I hereby request and authorize you to give:

	Medication/Treatment	Dosage	Time	Duration
1.				
2.				
3.				

Medical Diagnosis: _____

Comments: _____

_____

I understand the student (my patient) will carry this medication at school. I also understand this student (my patient) will be entirely responsible for the use of this medication and the use of this medication will not be monitored by school personnel.

Practitioner's Signature: _____ Date: _____

Print Practitioner's Name: _____ Phone: _____

Clinic Name & Address: _____ FAX: _____

TO BE COMPLETED BY PARENT:

I hereby give permission for my child to self-administer medication at school as prescribed by my child's physician, and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional. I understand my child will carry this medication at school. I also understand that my child is entirely responsible for the use of this medication and the use of this medication will not be monitored by school personnel.

I release all school personnel at Wabasha-Kellogg School District from any and all liability in the event of any adverse reactions from the use or administration of this medication. I hold all school personnel at Wabasha-Kellogg School District harmless from any liability resulting from allowing my child to self-administer medications during school hours.

Parent Signature: _____ Date: _____

WABASHA-KELLOGG SCHOOLS **School Year:_____**

STUDENT AGREEMENT FOR SELF ADMINISTRATION

Student Name: _____ Grade: _____

Medication: _____ Dosage: _____

I agree to:

1) Follow my prescribing health professional's orders

2) Use correct medication administration technique

3) Not allow anyone else to use my medication

4) Keep a current supply of my medication, located _____

5) Consult with the school nurse: weekly _____ monthly _____ other _____

6) Notify the school nurse or school personnel under the following circumstances:

- If the dosage or administration of this medication has been changed by your physician
- If my symptoms continue or get worse after taking the medication
- I suspect that I am experiencing side effects from the medication
- If my symptoms re-occur within 2 to 3 hours after taking medication
- Other: _____

I UNDERSTAND THAT PERMISSION FOR SELF-ADMINISTRATION OF MEDICATIONS MAY BE SUSPENDED IF I AM UNABLE TO MAINTAIN THE PROCEDURAL SAFEGUARDS ESTABLISHED ABOVE.

Signature of Student: _____ Date: _____

The student has demonstrated knowledge and understanding regarding proper use of his / her medication.

Signature of School Nurse: _____ Date: _____