

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 a container appropriately labeled by a pharmacist or the prescribing health professional. A written health care plan for the student must be developed by the school nurse. A student who has demonstrated competencies noted on his/her Individual Health Plan may then be allowed to self-administer medication if he/she signs the agreement on the back of this form.

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.

Amy Krebs, RN, Kim Pingel, LPN, Tammy Richard, RN,

Fax #'s: Elementary – 507-634-1240

Middle – 507-634-6485

High School – 507-634-4745

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

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

Medication	Route	Dose	Frequency
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I recommend self-administration of this medication for the treatment of: _____

Comments: _____

Discontinuation date: _____

Signature of Prescribing Health Physician	Print Name	Phone	Date
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I hereby give 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 professional.

Signature of Parent/Guardian Date

Self-Administration of Medication

Student Agreement

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips
- Notify the school nurse or health office personnel if the following occurs:
 1. My symptoms continue or get worse after taking the medication
 2. My symptoms reoccur within 2-3 hours after taking the medication
 3. I suspect that I am experiencing side effects from my medication
 4. Other _____
- I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

Signature of Student

Date

The student has demonstrated knowledge about and proper use of his/her inhaler.

Signature of School Nurse

Date

I have read the above student agreement.

Signature of Parent/Guardian

Date