

Stephen - Argyle Central

Self-Administration of Medications

School Year: _____

Student Name:	Grade:
Parent/Guardian Phone # (please specify)	

To Be Completed By Health Provider

It is in my professional opinion that the student named above is capable of carrying and self-administering the following medication:

Medication		Mediation	
Dose / Route		Dose / Route	
Frequency		Frequency	
Other Info		Other Info	

I recommend self-administration of the above mediation(s) for the treatment of _____

Symptoms should be checked by the Licensed School Nurse:

_____ daily _____ weekly _____ monthly _____ as needed/requested

Comments:

This expires at the end of the school year, unless otherwise noted: _____

Signature of Health Provider: _____ Date _____

Printed name and contact information:

To Be Completed by Parent/Guardian

I give my permission for my child to self-carry and self-administer during school hours as prescribed by my child's health provider. Should the need arise I give permission for the Licensed School Nurse to contact the health provider with questions or concerns. I will notify the school of any changes to the above medications, and supply new forms. My child will sign and follow the self-administration agreement. The medication will be supplied in the original prescription bottle/container/syringe with the student's name on it. I release the school personnel from liability in the event that an adverse reaction would occur as a result of taking the medication. If I choose, a supplemental bottle of the medication may be provided and stored in the school office (this must have the original or prescription label on it).

Signature of Parent/Guardian: _____ Date: _____

Stephen – Argyle Central

Self-Administration of Medications

Student:

School Year:

To Be Completed By Student:

I agree to:

- Follow my prescribing health provider's medication order
- Use correct medication administration technique
- Maintain a written record of my medication administration while in school if requested
- 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 office if any of the following occur:
 - o Symptoms continue or get worse after taking medication
 - o Symptoms reoccur within 2-3 hours after taking medication
 - o Suspect that I am experiencing side effects of my medication
 - o Other:

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the safety items listed above.

Signature of Student: _____ **Date:** _____

To Be Completed By Licensed School Nurse:

	Authorization for the Administration of Medications
	Self-Administration Form Signed by Health Provider
	Self-Administration Form Signed by Parents
	Self-Administration Form Signed by Student

	Medication is supplied in the original prescription bottle/container/syringe with the student's name on it
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The student has demonstrated knowledge about and proper use of the medication for self-administration.

Signature of Licensed School Nurse: _____ **Date:** _____