



Self-Administration of Medication(s) Form for Parent & Student

Dear Parent/Guardian:

CCA policy allows students to self-administer medications with school nurse and parent/guardian consent.* In order for your child to self administer his/her inhaler and/or epinephrine auto injector and/or insulin and/or other medication prescribed by a licensed physician, you must complete Part A of this form. Part B will be completed in the health office with your child. You may be present during the completion of part B of this form if you so desire.

Epinephrine injectors and respiratory inhalers are self-carried, at the nurses' discretion and with parental consent, as soon as student is able to meet that responsibility. Self-carrying of all other medications is dealt with on a case by case basis. Students are not allowed to self-carry ANY medications unsanctioned by the school nurse.

Epinephrine injectors not self carried are kept: one in the classroom and one in the nurses' office from 9-1:30 and the front office the remaining parts of the school day. Inhalers not self carried are kept in the nurses' office 9-1:30 and the front office the remaining parts of the school day.

A. To be completed by the parent/guardian:

I request that my child _____ be permitted to self-administer:

epinephrine injector respiratory inhaler other medication(s) _____

I request that my child be permitted to self carry (if applicable): N/A

epinephrine injector respiratory inhaler other medication(s) _____

My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying(if applicable) and using his/her medication. My child understands that if he/she self administers this medication while at school that he/she will inform the school nurse or closest adult immediately. It is understood that if there is irresponsible behavior or safety risk, the privilege of his/her medication will be rescinded.

I will support my child in following the agreement in Part B.

(Parent/Guardian Signature)

(Date)

B. To be completed by the school nurse:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Student is consistently able to : name the medication; identify the correct medication; explain the purpose of the medication; knows the correct dosage; explain when the medication is to be taken; describe what will happen if the medication is NOT taken. |
| <input type="checkbox"/> | <input type="checkbox"/> | Student demonstrated the correct use/ administration. |
| <input type="checkbox"/> | <input type="checkbox"/> | Student realizes his/her responsibility in carrying his/her own medication(s) (if applicable) and agrees not to share the medication(s) with others. |
| <input type="checkbox"/> | <input type="checkbox"/> | Student agrees to notify the school nurse or closest adult immediately after self administering his/her medication during school hours or on school-sponsored trips. |
| <input type="checkbox"/> | <input type="checkbox"/> | Student agrees to keep medication log and come to the health office immediately with any question, concerns or adverse side effects. |

The student understands that the privilege of self administering and self carrying (if applicable) his/her own medication(s) will be rescinded if he/she does not follow the above agreement.

	MEDICATION	LOCATION
This student will be self carrying the following:	_____	_____
	_____	_____
	_____	_____

(Student Signature)

(date)

(School Nurse Signature)

(date)

* Self administration may also require physician consent.