 **Self Administration Form**

District Policy allows students to self-administer certain medications at school and on school-sponsored field trips with parent/guardian permission and school nurse approval. Please complete Part A below. Part B will be completed by the school nurse and your child. Your child MUST be able to answer the questions in Part B in order to carry and self-administer medication.

1. **To be completed by Parent/Guardian:**

Name of child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

* My child has been instructed in how to administer the above medication.
* My child understands the purpose, dose, route of administration, frequency and use of the above medication.
* My child understands that they must notify the nurse or closest staff member/adult chaperone as soon as the medication is self-administered.
* My child understands that this medication is only for personal use and cannot be shared with others.
* I understand that if my child engages in behavior that a field trip chaperone feels is irresponsible or poses a safety risk, the permission to self-administer will be rescinded and I will be contacted.
* I will support my child in following the agreement in Part B.

Parent/Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. **To be completed by School Nurse & Student:**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **Student is able to consistently:** |
|  |  | identify medication |
|  |  | explain purpose of medication |
|  |  | state correct dosage |
|  |  | state when medication is to be taken |
|  |  | describe what will happen if medication is not taken |
|  |  | demonstrate correct administration |
|  |  | agrees not to share medication with others and to handle medication responsibly |
|  |  | agrees to notify nurse or supervising adult immediately after taking medication |
|  |  | agrees to notify nurse or supervising adult with any concerns, questions or adverse reactions/side effects |

**The student understands that the privilege of carrying and self-administering medication will be revoked if the above agreement is not followed.**

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**Student Signature /Date School Nurse Signature /Date**