Anoka Hennepin Health Service School Year _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

When a prescribing health professional, parent/guardian, student and Licensed School Nurse (LSN)/ Registered Nurse (RN) 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 student who has safely demonstrated skills necessary for using the prescribed medication, will then be allowed to self-administer medication once the student agreement is signed 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/RN. Orders must be renewed annually or whenever medication, dosage, or administration changes.

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

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

_____
Medication Route Dose Frequency

I recommend self-administration of this medication for the treatment of _____

- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use the medication.
- Student may self-administer the medication.

_____ _____
Print or Type Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____
Clinic Address Phone Number Date

I hereby give permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional. I give my medical provider and Anoka Hennepin permission to release and obtain information from each other as necessary. This authorization takes effect the day that I sign it. It expires one year from the date of my signature or the end of each school year, which ever comes occurs first. I understand that I may change this authorization at any time.

_____
Signature of Parent/Guardian Date

STUDENT AGREEMENT

I agree to:

- •Follow my prescribing health professional's 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 current supply of my medication located _____
- •Keep spare medication in the nurse's office.
- •Consult with the school nurse _____weekly _____monthly_____ other _____
- •Notify the school nurse or _____under the following circumstances;
  - _____ my symptoms continue or get worse after taking my medication
  - _____ I suspect that I am experiencing side effects from my medication
  - _____ other _____

I understand that permission for self-administration of medication may be suspended if I am unable to follow the procedure outlined.

_____

Signature of Student Date

NOTE: If the school nurse does not concur with the prescribing health professional's instructions after assessing the competencies of the student, the school nurse will contact the prescribing health professional to attempt to agree upon a plan. In the event agreement is not reached, the parents may refer the case to the district Health Service Consultant for resolution.

Permission for the self-administration of medication may be suspended if the student in unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the district Health Service Consultant for resolution.

This student has demonstrated mastery related to self administration of this medication.

_____

Signature of School Nurse/RN Date

I have read the above student agreement.

_____

Signature of Parent/Guardian Date

11/05
Form 1873