

HIGHLAND SCHOOL DISTRICT
Student Services Department

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name First Name Sex Birth date School

Name of Medication Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____
(Mouth, Ear, Eye, Etc.)

How long medication is to be taken? ☐ 1 year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis _____ ICD Code _____

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

This student's medical condition requires immediate use of _____ (medication) and the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

- ☐ The medication may have adverse side effects (explain): _____
- ☐ Special instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider Signature Date

Address City State Zip Code () Telephone

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Highlands School District from any and all rights or claims of any nature whatsoever I may have against The Highlands School District, the Board of Education of the Highlands School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

Print name of parent or guardian Signature Date

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Telephone Work telephone Cellular telephone

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal Signature of School Nurse Date

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)
 - ◆ Student's full name
 - ◆ Physician's name
 - ◆ Dosage, schedule, and route.
 - ◆ How long medication is to be taken? 1 year or short-term (date medication is to be discontinued or number of days medication is to be administered.)
2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.
3. Requests for Self-Administration of Medication during School Hours must be renewed annually. Parent/Guardian permission must be signed annually. An Individual Health Plan including an Emergency Care Plan must be developed.
4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.
5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.
Student Self-Administration of Emergency Medications
6. Student responsibility: The student shall demonstrate administration skills to the nurse and responsible behavior. The nurse shall provide periodic and ongoing assessments of the student's self-management skills. Students shall demonstrate a cooperative attitude in all aspects of self-administration of medication. Privileges for self-administration of medication will be revoked if school policies regarding self-administration are violated. The student shall notify the school nurse immediately following each occurrence of self-administration of emergency medication.