STUDENT HEALTH SERVICES EXHIBIT

Family Physician's Request for the Administration of Internal Medication

Under certain unusual circumstances when it is necessary for a student to take internal medication during school hours, the school nurse, classroom teacher, or a designated member of the school staff may cooperate with the family physician and with the parent(s) or guardian(s). If the parent(s) or guardian(s) submits a written request to the school authorities, which is accompanied by a written request from the family physician indicating the frequency and dosage of the prescribed medication, then the school nurse, classroom teacher, or a designated member of the school staff may administer this medication.

In compliance with the above, please submit the following information:

STUDENT'S NAME _____

ADDRESS _____

MEDICATION _____

DOSAGE _____

FREQUENCY _____

POSSIBLE SIDE EFFECTS _____

DOES THIS MEDICATION REQUIRE REFRIGERATION? _____

_____
Signature of Family Physician

_____
(Address)

_____
(Telephone Number)

Adoption date: June 19, 2002

STUDENT HEALTH SERVICES EXHIBIT

Student _____ School: _____

D.O.B. _____ Age: _____ Grade: _____

Medication: _____

Dose: _____ Time: _____

Self-Medication Criteria:

A. Student can identify medication: ( ) Yes ( ) No
Comments: _____

B. Student is knowledge of purpose of medication: ( ) Yes ( ) No
Comments: _____

C. Student is able to identify/associate specific symptom occurrence and need for medication administration: ( ) Yes ( ) No
Comments: _____

D. Student is capable/knowledgeable of medication dosage: ( ) Yes ( ) No
Comments: _____

E. Student is knowledgeable about method of medication administration:
( ) Yes ( ) No
Comments: _____

F. Student is able to state side effects/adverse reactions to his/her medication:
( ) Yes ( ) No
Comments: _____

G. Student is knowledge as to how to access assistance for self if needed in an emergency: ( ) Yes ( ) No
Comments: _____

Based on Assessment:

( ) Student is not a candidate for self-medication program at this time.
( ) Student is a candidate for self-medication program with supervision.

Nurse: _____
Date: _____
Adoption date: June 19, 2002
Revised: November 20, 2002

STUDENT HEALTH SERVICES EXHIBIT

Authorization for Self-Administration of Medication at School and at After School Activities

To be completed by the licensed healthcare provider

(Student's name): _____ has been instructed in the proper use of the following medication(s):

_____
_____
_____

In my professional opinion, this student should be allowed to carry and use the above medication(s) by him/herself.

_____ _____
(licensed prescriber's signature) (date)

To be completed by parent or guardian

I request that my child _____ be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medication(s) in his/her locker or PE locker, as I consider him/her responsible. The student has been instructed in and understand the purpose, appropriate method, frequency and use of his/her medication. The student understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

_____ _____
(parent/guardian signature) (date)

To be completed by school nurse

The licensed prescriber's statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

_____ _____
(school nurse signature) (date)

Adoption date: June 19, 2002
Revised: November 20, 2002

STUDENT HEALTH SERVICES EXHIBIT

Contract for Self-Administration of Medication

Student: _____ Grade: _____

Physician: _____ Telephone: _____

Medication: _____ Dose: _____ Time: _____

The Licensed prescriber's order and parent permission have been obtained for the student to carry and use his/her medication.

Student Responsibilities for Carrying and Using Mediation Observed:

Yes	No	
_____	_____	Student is consistently able to: identify the correct medication; identify the purpose of the medication; know the correct dosage; identify the time the medication is needed; describe what will happen if medication is not taken;
_____	_____	Student demonstrates the correct use/administration.
_____	_____	Student does not share medication with others.
_____	_____	Student will keep medication in agreed location: _____
_____	_____	Student will come directly to the Health Office if any of the following symptoms occur:
_____	_____	Student keeps a second labeled container in the Health Office.

The student does/does not demonstrate the specified responsibilities. The student may/may not carry his/her medication. If the student does not follow the above agreement, the privilege of carrying and using his/her medication will be rescinded.

_____ _____

(Student Signature/Date) (School Nurse Signature/Date)

It will support my child to follow the above agreement and if he/she does not, I will be contacted and a new plan will be developed with the school nurse.

Date from completed and returned to Health Office: _____

Adoption date: June 19, 2002
Revised: November 20, 2002