South Washington County Schools Independent School District 833 OFFICE OF SPECIAL SERVICES
7362 E. Point Douglas Road S. Cottage Grove, MN. 55016-3025

AUTHORIZATION TO SELF-ADMINSTER MEDICATION

Student Name_____ **DOB** _____ **School** _____

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

It is my professional assessment that this student is capable of carrying and self-administering the following medications: (check all that apply).

☐ Inhaler ☐ Epinephrine ☐ Insulin

Medication	Dose	Route	Frequency

Comments: _____

This student is knowledgeable about the medication and has the skills to safely self-administer.

SIGNATURE of Health Care Provider _____ CLINIC NAME _____

PRINTED Name of Health Care Provider _____ Phone Number _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to self-administer medication at school as prescribed by their health professional.

- Information regarding the above student's health condition may be shared with all appropriate school staff.
- I authorize reciprocal release of information related to the above student's health/medications between the school nurse and the prescribing health professional/clinic.
- I recognize that health records, once received by District 833, may no longer be protected by HIPAAA, but they will become education records protected by the Family Education Rights and Privacy Act (FERPA).

SIGNATURE of Parent/Guardian _____ Date _____ Phone Number(s) _____

NURSING ASSESSMENT TO BE COMPLETED BY LSN

The following information has been reviewed with the above student by the LSN.

☐ Review class schedule/activities which may impact health condition
☐ Knowledge of early warning signs of health condition
☐ Acute signs and symptoms of health condition
☐ Medication purpose (preventer or reliever)/dose/frequency/side effects
☐ Proper technique for medication administration
☐ Review emergency procedures
☐ Non-medication interventions (if applicable)
☐ Review student agreement

This student has demonstrated the knowledge and skill necessary to properly self-administer the above medication(s).

SIGNATURE of LSN _____ Date _____

STUDENT AGREEMENT

I agree to:

☐ Follow my health professional's prescribing orders for correct medication/dose and frequency
☐ Use the correct technique for administration of medication
☐ NOT allow anyone else to use my medication
☐ Keep a current supply of my medication at school
☐ Notify the school health staff, health assistant or nurse, if my symptoms continue or worsen, or I am experiencing side effects from my medication

If health status. Changes or student agreement is not followed, a reassessment will occur.

SIGNATURE of Student _____ Date _____

Upon receipt of this authorization, the school nurse is required by the Minnesota Nurse Practice Act to assess the student's knowledge and skills to safely possess and use this medication at school.