CENTENNIAL
SCHOOL DISTRICT 12
CONNECTING. ACHIEVING. PREPARING.

Authorization for Self-Carry/Administration of Emergency Medication

(Epinephrine Auto injectors, Inhalers, Insulin Pens)

This procedure was developed to comply with the Centennial School Board Policy, Minnesota Department of Health Guidelines for Medication Administration in Schools, and MN Statute 121A.22. It is designed to protect the health, safety and welfare of the student.

When prescribing health professional, parent/guardian, student, and school nurse agree that self-carry/administration of an Epinephrine Auto Injector, Inhaler, and/or Insulin Pen is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and this authorization must be completed each school year and whenever medication, dosage, or administration changes. The school nurse will assess the student's competencies to self-carry and/or self-administer medication and if there are any concerns will contact the healthcare professional and parent to discuss further options. In the event an agreement is not reached, the parents may refer the case to the Health Services Coordinator for resolution (Kelsi Gruber, RN, BSN, PHN, Licensed School Nurse: kgruber_kellerhuis@isd12.org/763.792.5231)

All self-carried or self-administered medication must be properly prescribed by a medical professional and must come from the pharmacy in a current pharmacy-labeled container. Pharmacy labels must be attached directly to epinephrine auto injectors, inhalers and insulin pens.

Student's Name___________________________________Birth Date______________Today's date______________

PHYSICIAN/LICENSED PRESCRIBER'S AUTHORIZATION TO SELF-CARRY/ADMINISTER

I certify that __________________________ is capable of self-carry and/or self-administration (circle one or both) the following medication:

Medication____________________________ Dose_____________________ Route ________________ per the

medication order/emergency action plan for treatment of ____.

Please check: YES _____ NO____ *I understand that self-administered medication is not provided by or monitored by the school staff.

Signature of Prescribing Health Provider____

Printed Name_______________________________ Clinic____________________ Date____________________

PARENT/LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION FOR SELF-CARRY/ADMINISTER

I request and authorize my child __________________________________ (first, last name) to carry and/or self-

administer (circle one or both) their medication ____________________________. (Name of medication)

This authorization is given based on the following:

- My child is capable of, has been instructed, and is competent in the proper method of self-administration of this medication and will consult with the school nurse as needed.
- My child will notify staff if epinephrine injection is administered.
- I understand that my child shall be permitted to always carry their medication, as long as they do not endanger him/herself or other persons and will not misuse the medication.
- I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from self-carry/self-administration of medication.
- I understand that this authorization may be revoked, and medication may be confiscated at any time if the child misuses and/or endangers others with the medication.
- I understand that I must report changes in medication, dose or administration to the school nurse.
- I hereby authorize reciprocal release of information related to the medication and diagnosis for which medication is prescribed between the school nurse and the healthcare professional/clinic.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.

Parent/Legal Guardian Name (Print): ____

Parent/Legal Guardian Signature: ____ Date:________________

Phone number: ________________

TO BE COMPLETED BY SCHOOL NURSE

☐ This student has demonstrated mastery related to his/her medication and self-carrying/administering skills (circle one or both).

☐ This student needs reinforcement of his/her medication and self-carrying/administering skills.

Signature of School Nurse_______________________________________ Date_________

NOTE: The school nurse will assess the student's competencies to self-carry and/or self-administer medication and if there are any concerns will contact the healthcare professional and parent to discuss further options.