



School Year: _____

Self-Administration/Self-Possession of Medication

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate self-administration. Please complete this form if you want this student to self-administer and self-possess their medication while in school.

Student Name: _____ DOB: _____ School: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis for Medication: _____

Medication Name	Dose	Time To Be Given <small>*If PRN please indicate how often medication can be given*</small>	Route	Side Effects	Special Instructions <small>(Such as "take with food")</small>

Start Date: _____

Stop Date: _____

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: _____

Physician Signature

Date

Physician Printed Name

To be completed by parent/guardian:

I am giving permission for my child _____ to: self-administer self-possess the above medication according to the school district policy and for the physician and school district staff to share information regarding my child's medication needs.

Parent/Guardian Signature

Date



School Year: _____

Student Name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled prescription or over the counter container
3. Take the medication only at the prescribed time, frequency and dose.
4. Carry a copy of this form with me and present it to the school staff if asked.

I understand if I do not comply with this agreement then the medication will be confiscated and returned to my parent/guardian and my privilege of self-administration/self- possession will be denied.

Student Signature

Date



School Year: _____

**POLICY CONCERNING ADMINISTRATION OF
MEDICATIONS/MEDICAL PROCEDURES BY SCHOOL DISTRICT PERSONNEL**

HOLD HARMLESS AND INDEMNIFICATION

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to _____
_____, as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any
other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board
of Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities,
demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties
listed above or against any other person associated with the Southgate Community School District under any legal theory based upon
or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures
to _____.

Witnesses:

Date

Signature of Parent/Guardian

Telephone No. (Home)

Emergency Contact Name

Emergency Contact Number

Asthma Action Plan for Home & School

Name:

Birthdate:

Asthma Severity:

- Intermittent Mild Persistent Moderate Persistent Severe Persistent
 He/she has had many or severe asthma attacks/exacerbations

 **Green Zone** Have the child take these medicines every day, even when the child feels well.


Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

 **Yellow Zone** Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed


Controller Medicine(s):

Continue Green Zone medicines: _____

Add: _____

Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

 **Red Zone** If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.

Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

- Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
 School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:

Asthma Provider Signature:

Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature:

School Nurse Reviewed:

Date:

Date:

Please send a signed copy back to the provider listed above.