Forest Lake Area Schools
Health Services - Nursing

Self-Carry/Self-Administration of Medications at School Authorization Form

School: _____ Year: _____

Student Name: _____ Birthdate: _____ Grade: _____

Procedure for students to self-carry and administer **emergency prescription medications (K-12, grades K-6 on a case by case basis) and/or OTC pain relief medications (grades 7-12 Only):**

- OTC medications must be in the original manufacturer's bottle, unopened with the label intact. Parents must label the bottle with the student's name
- Signed parental consent is required for OTC Pain Relief Medications
- **Over the Counter pain relief medications: Acetaminophen (Tylenol) and/or Nonsteroidal Anti-Inflammatory Drugs (NSAIDS), Ibuprofen or Naproxen only, no combination medication.**
- Emergency prescription medications must be in the original prescription bottle/box labeled by the pharmacist. The label must match the provider/prescriber order and include: student's name, name of medication, dosage, route, frequency and expiration date
- Provider/prescriber and parent acknowledgement to self-carry/self-administer required for emergency prescription medications (ie. Epinephrine/inhalers).
- Parents will direct the student on proper dosage and frequency per label directions
- Permission will be revoked if the school determines that student is abusing the privilege
- No products containing ephedrine or pseudoephedrine as an active ingredient are allowed
- Authorization must be renewed for each school year
- Student must not share medication with any other students
- Student will seek assistance from the Health Office staff if they experience unusual side-effects or do not experience relief as expected from their medication

TO BE COMPLETED BY PARENT/GUARDIAN & PROVIDER:
Medication is permitted in accordance with the district policy and procedure(s). In addition to the parent/legal guardian, the student's licensed prescriber/physician must authorize self-carried prescription medications. Student's name must appear on the medication container, inhaler or injector.

List Medication names below:	**Indicated Diagnosis:**
_____	_____
_____	_____
_____	_____

☐ It is my opinion that the above listed student is capable of carrying and self-administering the listed medication(s). I have directed the student on the proper dosage and frequency per label directions.

_____ _____
(Parent/Guardian Printed Name) **(Parent/Guardian Signature)**

☐ It is my professional opinion that the above listed student is capable of carrying and self-administering the listed medication(s)

_____ _____

(Provider/Prescriber Printed Name) **(Provider/Prescriber Signature)**

Student Agreement:

I, _____agree to the responsibilities of carrying medication.

SKILL	STUDENT INITIALS	NURSE INITIALS	COMMENTS
Medication will be properly labeled for the student by pharmacist (prescription) or parent (OTC).			
Student demonstrates correct use/administration of medication			
Student can recognize correct dosage			
Student recognizes proper and prescribed timing for medication			
Student agrees to not share the medication with others			
Student will keep the medication in an agreed upon location • Location: _____			
Student will keep a second labeled container in the health office (optional)			
Student will notify the Health Services Office under the following circumstances: • Symptoms continue or get worse after taking my medication • Suspect that I am experiencing side effects from the medication • Other_____			

Permission for self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Building Principal and District Nurse.

☐ The student has demonstrated the specified responsibilities and may self-carry/administer the indicated medications.

_____ _____ _____

(Student Signature) **(RN/LSN Signature)** **(Date)**