

POSSESSION AND SELF-ADMINISTRATION OF CERTAIN MEDICATIONS

Students with diagnoses of asthma, severe allergies, and cystic fibrosis are permitted to possess and self-administer their medications in accordance with this policy during the school day, at school-sponsored activities, or while on a school bus or other school property. In order for a student to possess and self-administer medication, the following conditions must be met:

Written parental consent that the student may self-administer medications;

Written notice from the student's primary care provider, indicating the identity of the student, stating the diagnosis and approving self-administration of necessary medications that have been prescribed for the student; specifying the name and dosage of the medication, the frequency in which it is to be administered and the circumstances which may warrant its use; and attesting to the student's demonstrated ability to safely and effectively self-administer the medication;

An individualized health care plan must be prepared, including emergency procedures for any life-threatening conditions; and

Information regarding the health condition of the student may be disclosed to school board employees in accordance with state and federal laws governing the disclosure of information contained in the student's scholastic records.

Permission granted to a student to possess and self-administer certain medications will be effective for a period of one school year, and must be renewed annually. However, a student's right to possess and self-administer inhaled medication may be limited or revoked after appropriate school personnel consult with the student's parents.

Any student with permission to possess and self-administer inhaled medication and is found to abuse it's regulations, shall have this privilege revoked.

CONTRACT FOR SELF-CARRIED MEDICATION

Student: _____ Grade: _____
Physician: _____ Telephone: _____
Medication: _____ Dose: _____
Time: _____

Medication is permitted in accordance with district policy. Student's physician must authorize self-carried/administered medication. Student name must appear on the medication container or inhaler.

Responsibilities for carrying medication

Observed

Yes No

_____	_____	Health care action plan complete
_____	_____	Demonstrated correct use/ administration
_____	_____	Recognizes proper and prescribed timing for medication
_____	_____	Does not share medication with others
_____	_____	Keeps medication in agreed location
_____	_____	Keeps a second labeled container in the Health office
_____	_____	Agrees to come directly to the Health office if having the following symptoms after using medication:

The student does/does not demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.

Comments and added responsibilities:

(Student/date)

(School Nurse/date)

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and we will develop a new plan.

(Parent/guardian/date)

(Parent daytime telephone numbers)

**AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE
AT SCHOOL AND AFTER-SCHOOL ACTIVITIES**

School Board policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic reaction, or diabetes on his/her person for immediate use in the life threatening situation with written order of physician, parent consent, school nurse and principal approvals.

PHYSICIAN / HEALTH CARE PROVIDER ORDER

Student: _____ DOB: _____
Address: _____
School: _____ Grade: _____
Condition for which the medication is administered _____
Name of medication _____
Dose _____ Method administered _____
Time or indication for administration _____
Is this a controlled drug? ____ Yes ____ No
Side effects to be noted/reported _____
Other recommendations _____
Duration of administration; From _____ to _____ (within current school year)
IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Physician Signature

Print Name

Telephone numbers

Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in its original container, labeled with name of student and name of medication. No more than a 45 school day supply of medication will be kept at school. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.

