EMPOWER ONE
LEXINGTON COUNTY SCHOOL DISTRICT ONE

Lexington County School District One

Self-Medicating and/or Self Monitoring Student

School Year:_____

For school use only:

Date Received: _____

When completing this form, draw an "X" through any sections that do not apply. (Example: If you will not be self-monitoring, draw an "X" through the self-monitoring section.) A new application for self-medicating and/or self-monitoring must be **completed each school year.** Permission from the student's health care practitioner is required for self-administration of medications and/or self-monitoring. An approved Individual Healthcare Plan (IHP) is also required. Students are not permitted to self-administer medications that are controlled substances.

The school district and its employees and agents are not liable for an injury arising from administration of medication/treatments authorized by an IHP. I agree to indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication/treatments authorized by an IHP.

Student's Name _____ Date of Birth _____

Name of School _____ Grade _____ Homeroom Teacher _____

List the medication(s) that you will be self-administering.	**List the monitoring device(s) that you will be using.**
Please read and initial each statement below if you agree. All are required in order to self-administer medications at school. I know when I should and when I should not take the medication(s) noted above. _____ I know the signs and symptoms that may mean that I should not take the medication(s). _____ I know how much of the medication(s) noted above I should take. _____ I know how to take the medication(s) noted above. _____ I will take the medication(s) the way that my health care provider has instructed._____ I will keep the medication in the package provided by the pharmacy or my health care practitioner. _____ I will keep the medication and any supplies needed for taking the medication(s) with me in a safe place. _____ I will not allow other students to touch or hold my medication(s) nor any of the supplies needed for taking the medication. _____ I understand that I will no longer be able to take my medication on my own if I endanger myself or another student by misusing the medication(s)._____ I understand that I can only take the medication(s) noted above on my own. All other medications must be given to me by a school employee. _____	**Please read and initial each statement below if you agree. All are required in order to self-monitor at school.** I know when I should and when I should not use the monitoring device(s) noted above. _____ I know the signs that may mean that the monitoring device(s) is/are not working properly. _____ I know how often to use the monitoring device(s). _____ I will keep the monitoring device(s) and any supplies needed for using the monitoring device(s) with me in a safe place. _____ I will not allow other students to touch or hold my monitoring device(s) nor any of the supplies needed for using the monitoring device. _____ I understand that I will no longer be able to use the monitoring device(s) on my own if I endanger myself or another student by misusing the device(s). _____ I understand that I can only use the monitoring device(s) noted above on my own. All other devices must be used with the assistance of a school employee. _____

Student's Signature _____ Date _____

Parent's/Guardian's Signature _____ Date _____