DORCHESTER SCHOOL DISTRICT TWO
2026-2027 REQUEST FOR MEDICATION
SELF-MONITORING OR SELF-ADMINISTRATION

INTERNAL USE ONLY:

- ☐ **Order Entered into SNAP**
- ☐ **ICD-10/Billable Time**
- ☐ **Order Scanned into SNAP**
- ☐ **Condition Entered**
- ☐ **IHP Created**
- ☐ **EAP Created (if needed)**

The following is to be completed by a physician/legal prescriber. *One medication and/or dose per form.*

Name of Student: _____ DOB: _____Grade_____

Name of Medication: _____ Dosage: _____

Medication is prescribed for: _____ ICD-10 Code: _____

If PRN, list indication(s): _____

Time(s) to be taken at school: _____ Start Date: _____ End Date (if applicable) *: _____

*UNLESS OTHERWISE INDICATED, THESE ORDERS ARE VALID THROUGH CURRENT SCHOOL YEAR, INCLUDING SUMMER PROGRAMMING

List any potential reactions with appropriate treatment: _____

Check one box **only:**

☐ This request is for **self-carry ONLY.** The student **will not** be able to self-administer this medication and will require assistance from school staff to administer.

☐ This request is for **self-carry AND self-administer**. The student **may** carry his/her own medication and will self-administer when necessary per the orders above.

- I hereby request and authorize this student to self-carry and/or self-administer this medication in accordance with the orders listed above. I verify that this student's medical condition is such that self-monitoring and/or self-administration of a prescribed medication for this condition at school, on school grounds, at school-sponsored activities, or during before-school or after-school activities on school-operated properties is appropriate.
- I further verify that the student has been trained & has demonstrated competency in self-monitoring and/or self-administration of a prescribed medication for this condition.

_____ _____

Physician/Legal Prescriber Signature of Physician/Legal Prescriber

_____ _____ _____

Office Phone Number Office Fax Number Date

The following is to be completed by a parent/legal guardian and student.

- I hereby authorize my child to self-carry and/or self-administer medication as ordered by his/her health care practitioner as described above while at school, on school grounds, at school-sponsored activities, or during before or after-school activities on school property.
- I understand that Dorchester District Two reserves the right to approve, deny or revoke this request & submission of this form does not guarantee that my child can self-carry/self-medicate. I understand that this authorization must be updated annually & with any changes.
- I understand that if my child is not authorized to self-administer per the provider's order above or my child is unable to self-administer in an emergency, school staff may assist my child in doing so. I further understand it is parent/guardian and/or student responsibility to ensure that needed medication is available (present, labeled, not expired, etc.) as it will not be stored/maintained by school staff.
- I understand that all medications approved for self-carry and/or self-medicate must follow all DD2 policies and procedures for medication in school, including proper labeling, storage, and safety.
- I hereby acknowledge that Dorchester School District Two, its employees & agents, are not liable for any injury arising from my child's self-monitoring or self-administration of a prescribed medication. Further, I hereby agree to indemnify & hold harmless the former against any claims arising from my child's self-monitoring and/or self-administration of a prescribed medication.

_____ _____

Signature of Parent/Legal Guardian (required) Date

_____ _____

Signature of Student (required) Date