LEXINGTON COUNTY SCHOOL DISTRICT ONE

School Health Services
Self-Medicating and/or Self-Monitoring
Health Care Provider Authorization
Parent/Guardian Permission and Student Agreement

This form must be completed by the health care provider who prescribed the student's medication or monitoring device. Note that students will not be permitted to self-administer medications that are classified as controlled substances. Medications must be kept by the student in the container labeled by the pharmacist who filled the prescription. An approved Individual Healthcare Plan (IHP) is required for students who will self-administer medication(s) and/or self-monitor. A new form must be completed each school year.

Student Name	School	DOB	Grade	Diagnosis

Allergies	ICD-10 code	Medication(s)/Procedure(s) being authorized:

The student named above

a. **has been instructed regarding the appropriate use of the medication(s)/procedure(s) noted above (understands indications, actions, side effects, when to administer and when not to administer, and when to seek assistance).**
b. **has demonstrated competency for safely self-administering the medication(s)/procedure(s) noted above.**
c. **will be responsible for the proper use and safekeeping of the medication/supplies/equipment. Medications must be kept in the container provided by the pharmacist or health care provider. The container must have the student's name, medication name, dosage of the medication, and the directions for proper use on it.**

I understand the student may only self-administer the medication(s)/ procedures(s) noted above. All other medications must be given to the student by a school nurse or trained district employee.

I understand the student will lose the privilege to self-administer medication(s)/ procedure(s) if the student endangers herself/ himself or another student by misusing the medication(s)/ equipment.

I agree that the student named above should be allowed to possess and self-administer the medication(s)/procedure(s) noted above as prescribed while in the classroom and any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property.

I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this "Self-Medicating/ Self-Monitoring" form to apply if I transfer my child to another school in this same school district during the current school year.

I understand that the school may require that I agree to the school district's rules about medications prior to the administration of this medication. I understand that I am responsible for notifying the school if my child's medications change in any way. I give permission for a trained district employee to assist my student with medication in the absence of the school nurse.

The school district and its employees and agents are not liable for an injury arising from administration of medication/treatments authorized by an IHP.

The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication; the administration of medication authorized by an IHP; or any administration of medication.

Prescribing Health Care Practitioner Signature:	Date:
Health Care Practitioner Printed Name:	**Office Phone Number:**
Parent/Guardian Signature:	**Date:**
Student Signature:	**Date:**