Charleston County
SCHOOL DISTRICT

Medication/Procedure Doctor's Orders

School Year: _____

To Be Completed by Legal Prescriber *(This order is valid through the end of the school year and new orders are required each year)*

Name of Student: _____ Date of Birth: _____

School: MOULTRIE MIDDLE SCHOOL School Phone/Fax: (843) 856-6722 ; 854-800-4073

Diagnosis: _____

List any known drug allergies or other allergies: _____

Medication	Indication	Dosage	Potential side effects	Comments/special instructions

Medication and/or Procedure
___ This student has been instructed and is competent in proper use of medication and/equipment (understands indications, actions, side effects, when to administer, and when not to administer and when to seek assistance). This student should be allowed to possess and self-administer the listed medication(s) and/or procedure(s) in any area of school or at any school sponsored activity in transit to and from school sponsored activities, and before and after school activities on school property.

Special Procedure: _____ Catheterization _____Tube feeding _____Other

This student's specific information will be used to individualize the CCSD Health Management Plan and Emergency Action Plan that will be shared on need-to-know basis for student safety.

_____	_____	_____	_____
Legal Prescriber, print name	Signature of Legal Prescriber	Date	Phone/Fax

_____	_____	_____	_____
Signature of Parent/Legal Guardian	Date	Phone	Email

Charleston County
SCHOOL DISTRICT

Self-Medication and/or Procedure

Parent/Guardian Permission and Student Agreement

Student's Name _____ **DOB** _____

Name of School _____ **Grade** _____ **Homeroom Teacher** _____

Medication/Procedure: _____

Parent Consent: *Read and check each statement, if you agree. All are required for self-medication(s)/procedure(s) at school.*

☐ I authorize my child to possess and self-administer the medication(s)/procedure(s) noted above as prescribed while in the classroom and in 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.

☐My child has been instructed about the proper use of the medication(s)/procedure(s) noted above.

☐ My child has shown me that he or she can safely self-administer the medication(s)/procedure(s) noted above.

☐My child and I will be responsible for the proper use and safe-keeping of the medication(s)/equipment.

☐I will not hold the school district or any of its employees or agents liable if an injury occurs related to my child self-administering medication(s)/procedure(s). I will be responsible for any costs related to any claims that occur related to my child self-administering medication(s)/procedure(s).

☐I understand that my child will lose the privilege of self-administering medication(s)/procedure(s), if student endangers self or another student by misusing the medication(s)/equipment.

☐I understand that my child may only self-administer the medication(s)/procedure(s) noted above. All other medications must be given to my child by a school employee.

☐ I understand that my child must keep his or her medications in the container provided by the pharmacist or my child's health care practitioner and must have my child's name, the name and dosage of the medication, and the directions for proper use on it.

Parent Signature: _____

Date: _____

Medication/Procedure: _____

Student Consent: *Read and check each statement, if you agree. All are required for self-medication(s)/procedure(s) at school.*

☐I know when I should and when I should not take the medication(s)/perform the procedure noted above.

☐I know the signs and symptoms that may mean that I should **not** take the medication(s).

☐I know the signs and symptoms that may mean that I should take the medication(s)/perform the procedure(s).

☐ I know how much of the medication(s) noted above I should take.

☐I know how to take the medication(s)/perform the procedure(s) noted above.

☐I will take the medication(s/perform the procedure(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)/performing the procedure(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/equipment needed for taking the medication(s)/performing the procedure(s).

☐ 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)/equipment.

☐ I understand that I can only take the medication(s)/perform the procedure(s) noted above on my own. All other medication(s)/procedure(s) must be given to me by a school employee.

Student Signature: _____

Date: _____