Perham/Dent Public Schools – ISD 549

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Sue Seip - RN, LSN

PRESCRIPTION MEDICATION SELF CARRY AND SELF ADMINISTRATION AUTHORIZATION FORM (TO BE USED FOR INHALERS, EPI-PENS, INSULIN PUMPS)

STUDENT: ______________________________________ SCHOOL: ______________________
SCHOOL YEAR:______________ DOB: __________________ DATE:____________________

PHYSICIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION:
As the physician for the above named student, I have prescribed medication for the student which must be administered during school hours. The medication ordered is as follows:

ILLNESS/MEDICAL CONDITION BEING TREATED: ____________________________________
MEDICATION: ____
DOSE: _____ ___________________________________ROUTE:__________________________
TIME/FREQUENCY: ____
CONTINUE UNTIL: ____

I have reviewed the medication with the student and the student's parents, and the medication may be self-administered by the student during school hours.

PHYSICIAN SIGNATURE______________________________________DATE_________________________
PHONE:____
ADDRESS: ____

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The undersigned, as parent(s)/guardian of the above named student, request permission for, and hereby authorize, the student to self-administer the above named medication during school hours. Further, the undersigned acknowledge and understand the following:

1. Medication shall be maintained in the original prescription container with original label.

2. School personnel may examine the medication container upon request, and any medications not maintained in the original container may be confiscated by school personnel.

3. The school may require the student to store the medication in a central location in the school.

4. The undersigned has reviewed the medication administration procedure with the student and believe student understands the administration procedure and is capable of self-administering the above medication

5. The undersigned will notify the school immediately if the student's health status changes, or there is a change or cancellation of this medication.

6. School employees and personnel will not be involved in the administration of the above medication and will not be monitoring the student for side effects or student's failure to take the medication. The undersigned and student shall be solely responsible to assure that the medication is taken as prescribed.

7. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

PARENT/GUARDIAN:____ DATE:____________
PHONE: (H) ____________________ (W)______________________(other)_______________

Revised 5/17/10