Royalton Public Schools Medication Authorization Form 4A

SELF CARRIED/SELF-ADMINISTERED PRESCRIBED MEDICATION AGREEMENT & EVALUATION FORM

This form is used once a physician's order is obtained for students to carry/self-administer an Inhaler or EpiPen Injector or Insulin Injector. Student's name and dosage instructions must appear on the inhaler, or injector.

To be filled out by School Nurse:

Student _____ Grade _____DOB_____

Medication_____ Dose_____ Frequency_____

Physician Name _____ Phone Number _____

To be reviewed with student and school nurse. **All** boxes must be checked in order to be approved by the school nurse.

- The student can demonstrate correct use/administration
- The student recognizes proper and prescribed timing for medication
- The student agrees to not share medication with others
- The student will keep the medication in an agreed location (indicate location)_____
- The student agrees to come directly to the health office if having the following symptoms after using medication:

_____

The student may carry the medication unless and until he/she fails to follow the above agreement. Yes / No

Any Comments/Added Responsibilities:

_____

_____

_____

Student agrees to the above plan: Yes / No

Student Signature: _____Date: _____

School Nurse Signature _____ Date: _____

Parent Agreement and Permission

I request that my child be allowed to carry his/her medication as listed above and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and a new plan will be developed. To the legally extent permissible, staff members may be provided with such information regarding the student's medication and student's self-administration as may be in the best interest of the student.

Parent/Guardian Signature: _____Date: _____

Daytime Phone Number: _____