



South Washington County Schools
 Independent School District 833
 OFFICE OF SPECIAL SERVICES
 8400 E. Point Douglas Road S.
 Cottage Grove, MN 55016-3324

Student _____	
DOB ____/____/____	School _____
Grade _____	School Year 20 ____/20____
<input type="checkbox"/> Student has 504 Plan	<input type="checkbox"/> Student has IEP

AUTHORIZATION TO SELF-ADMINISTER MEDICATION

Revised:
JUNE 2016

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

It is my professional opinion that this student is capable of carrying and self-administering the following medications: (Check all that apply.)

- Inhaler Epi Pen Insulin

Medication	Dose	Route	Frequency
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COMMENTS: _____

- **This student is knowledgeable about the medication and has the skills to safely self-administer.**

SIGNATURE of Health Care Provider

CLINIC Name

PRINTED Name

Phone Number

Date

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to self-administer medication at school as prescribed by my child's health professional.

- Information regarding my child's health condition may be shared with all appropriate school staff.
- I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing health professional/clinic.
- I will inform the health office of any change in medication and the status of my child's health condition.
- The school is released of liability in the event that adverse reactions result from my child's self-administration of medication.
- I recognize that health records, once received by District 833, may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Signature of Parent/Guardian

Date

Daytime Phone Number(s)

Upon receipt of this authorization, the school nurse is required by the Minnesota Nurse Practice Act to assess the student's knowledge and skills to safely possess and use this medication at school.

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION

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NURSING ASSESSMENT TO BE COMPLETED BY DISTRICT 833 LSN

The following information will be reviewed with students who intend to self-carry medication with them for use during the school day:

- Review class schedule/activities which may impact health condition
- Knowledge of early warning signs of health condition
- Acute signs and symptoms of health condition
- Medication purpose (preventer or reliever)/dose/frequency/side effects
- Proper technique for medication administration
- Review individual health plan and/or emergency care plan
- Non-medication interventions (if possible)
- Explain student agreement at time of nursing assessment

This student has demonstrated the knowledge and skill necessary to properly administer the above medication.

Signed: _____ Date: _____
Licensed School Nurse

SELF MEDICATING AUTHORIZATION RECEIVED: Physician Parent

STUDENT AGREEMENT

I agree to:

- Follow my health professional's prescribing orders for correct medication/dose and frequency
- Use the correct technique for administration of medication
- NOT allow anyone else to use my medication
- Keep a current supply of my medication at school
- Notify the school health staff, health assistant or nurse, if my symptoms continue or worsen, or if I suspect I am experiencing side effects from my medication

If health status changes or student agreement is not followed, a reassessment will occur.

Signed: _____ Date: _____
Student Signature