ISD#110 Waconia Public Schools
Learning for Life

Building: ☐ High School ☐ Clearwater ☐ Southview ☐ Bayview ☐ _____

School Year: _____

AUTHORIZATION TO SELF-CARRY/SELF-ADMINISTER MEDICATION(S)

To be completed by Prescribing Health Professional

I believe that _____ is capable of self-carrying/self/administering the following medication(s):
Note: only the following medications are allowed for student self-carry/administer – prescription asthma medications, prescription epinephrine, and secondary students may self-carry and use non-prescription pain relievers in a manner consistent with labeling/packing.

Medication	Route	Dose	Frequency
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I recommend self-administration of this medication(s) for the treatment of:_____

Comments:_____

Discontinuation date:_____

_____
Signature of Prescribing Health Professional

_____ _____ _____

To be completed by Parent/Guardian

I hereby give my permission for my child to self-carry/self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional/clinic.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Work phone number or other daytime phone number Cell phone or pager number

Please complete reverse side →

To be completed by Student

I agree to:

Follow my health care provider's orders and Emergency Care Plan

Refill my prescriptions before they expire (or remind my parent/guardian to do so)

Use correct medication administration technique (demonstrate to nurse)

Not allow anyone else to use my medication

Keep a current supply of my medication, located:_____

Check-in with the school nurse: _____weekly _____monthly _____other

Notify the school nurse or_____ under the following circumstances

- Questions or concerns regarding medication
- If I have any symptoms of an allergic reaction

_____ _____

Signature of Student Date

To be completed by Licensed School Nurse/Health Associate

This student has demonstrated mastery related to his/her medication and self-carrying skills

This student needs reinforcement of his/her medication and self carrying-skills

This student may self-carry/self-administer and should check in with Health Services
_____weekly _____monthly _____daily other_____

_____ _____

Signature of Licensed School Nurse/Health Associate Date

NOTE: Health Services will assess the student's competencies to self-carry and/or self-administer medication and if there are concerns, will contact the health care provider and parent to discuss further options. If agreement is not reached, the parents may contact the Superintendent of Schools. Permission for self-carry/self-administration may be suspended if the student is unable to follow the above procedure. If there is a disagreement concerning this procedure, the Superintendent of Schools should be contacted.

High School	**Clearwater Middle**	**Southview Elem.**	**Bayview Elem.**
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