ISD#110 Waconia Public Schools
Learning for Life

Building: ☐ High School ☐ Clearwater ☐ Southview ☐ Bayview ☐ Laketown ☐ DO

School Year: _____

AUTHORIZATION TO SELF-CARRY/SELF-ADMINISTER MEDICATION

Non-Prescription Pain Relievers (Secondary Students 7-12th ONLY)

TO BE RENEWED EACH SCHOOL YEAR

To be completed by Parent/Guardian

I believe that _____ is capable of self-carrying/self/administering the following non-prescription pain relievers per label instructions. *Note: pain relievers cannot contain ephedrine or pseudoephedrine as its sole ingredient or as one of its active ingredients.*

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

Comments:_____

_____

Discontinuation date:_____

I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication(s). I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-carry/self-administer medication at school as directed 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 – Student Agreement

Medication is permitted in accordance with district policy and procedures. In addition to the parent/guardian authorization to self-carry and self-administration of medication(s) the student must complete the below student agreement. Student name must appear on the medication container and student must follow directions as identified on medication label.

I _____agree to the responsibilities of carrying medication(s)

- ☐ Possess and use non-prescription pain reliever(s) in a manner consistent with labeling
  - Recognize correct dosage and proper timing for medication
- ☐ Refill my medication(s) 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:_____
- ☐ Notify the school nurse or_____ under the following circumstances
  - Questions or concerns regarding medication
  - Suspect that I am experiencing side effects from the medication and/or am having an allergic reaction
  - Symptoms continue to get worse after taking my medication

_____ _____

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

The student **is / is not** able to demonstrate the specific responsibilities related to self-carrying and self-administration of medication(s). The student may carry the medication(s) unless and until he/she fails to follow the above agreement.

_____ _____

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 District Health Coordinator or School Administrator. Permission for self-carry/self-administration may be suspended if the student is unable to follow the above procedure.

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