Self-Administration of Non-Prescription Medication

Name_____Birthdate_____Grade_____

The medication must be brought to school in an original container. Non-prescription pain medication may include only: naproxen, ketoprofen, ibuprofen or acetaminophen. ***Medications containing ephedrine, pseudoephedrine or diphenhydramine may not be self-administered at school. Medications not regulated by the FDA may not be self-administered at school.***

A student, who has safely demonstrated skills necessary for using the non-prescription pain medication, will then be allowed to carry and self-administer medication once the student agreement is signed on this form.

This form must be completed by the parent/guardian and returned to the school nurse. Orders must be renewed annually or whenever medication, dosage, or administration changes.

TO BE COMPLETED BY PARENT/GUARDIAN AND MEDICAL PROVIDER

I believe that_____ is capable of self-administering the following medication:
(Student's Name)

Medication: _____Dose: _____ Time: _____

Medication: _____Dose: _____ Time: _____

I request self-administration of this medication for the treatment of_____

*Student may self-administer the medication

*Student is knowledgeable about the medication and knows how to administer it.

*Student has the skills to safely possess and use the medication.

Print Doctor's Name _____*Print Clinic Name*_____

Physician Signature_____

Phone/*Fax Number*_____

I hereby give permission for my child to self-administer medication. I give my medical provider and Farmington Health Services permission to release and obtain information from each other as needed. This authorization takes effect the day I sign it. It expires one year from the date of my signature. I understand that I may change this authorization at any time.

_____ _____

Signature of Parent/Guardian **Date**

Student agrees to:

* Follow my parent/guardian instruction.
* Use correct medication administration technique. * Not allow anyone else to use my medication.
* Notify the school nurse if:
  _____ my symptoms continue or get worse after taking my medication
  _____ I suspect that I am experiencing side effects from my medication

I understand that permission for self-administration of medication may be suspended if I am unable to follow the procedure outlined.

Signature of Student: _____Date: _____

Signature of Building Nurse: _____Date: _____