FRANKLIN
ACADEMY

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT _____ **BIRTHDATE** _____ **SCHOOL** _____

TEACHER _____ **GRADE** _____ **SCHOOL YEAR** _____

THIS SECTION TO BE COMPLETED BY STUDENT'S LICENSED HEALTH CARE PROVIDER

Medication will be given to a student at school only when absolutely necessary. Whenever possible, the parent and licensed health care provider (LHCP) are urged to design a schedule for giving medication outside of school hours. **ONLY ONE MEDICATION PER FORM**

Diagnosis/reason for medication:_____

Name of Medication: _____ Dose to be given:_____

☐ Oral ☐ Inhaler ☐ Topical ☐ Eye Drops ☐ Ear Drops

Specific Time (s): _____ and frequency of administration_____

Directions:_____

Anticipated Action of Medication: _____

Length of Prescription Period: ☐ Current School year (including Summer School) ☐ Other _____

Side Effects: _____

I certify that valid health reasons exist requiring that the above medication be administered during school hours or during such time that the student is under the supervision of school officials.

I believe it is in the student's best interest to self-medicate and I authorize the above-named student to self-administer the above-identified medication in accordance with the instructions indicated.

_____ Date of Signature

_____ Licensed Health Care Provider's Signature

_____ Telephone Number

_____ LHCP name (Print or Type)

The Parent/Guardian section is to be completed on back of this form.

OVER

GUIDELINES FOR PARENT/GUARDIAN REGARDING SELF-ADMINISTRATION OF MEDICATIONS AT SCHOOL

1. A written authorization form must be signed by the Licensed Health Care Provider (LHCP) and parent indicating the dosage of the medication, dates, and times it is to be taken. This completed form must be returned prior to the student initiating self-medication and will be kept on file in the school.

2. The medication must be furnished in a current, original container from the pharmacy with the student's name, the name of the medication, strength and dosage to be taken. Non-prescription medication must be furnished in the original container from the manufacturer.

3. Except in the case of multi-use devices (i.e. asthma inhalers), any student who is authorized to medicate himself/herself at school should carry only one day's dosage of the medication in the current, original container.

4. If the dosage or time of medication changes, the LHCP must complete a new authorization form. A new, labeled container from the pharmacy indicating the new dose or time is also required.

5. The student is allowed to possess and use his/her medication while in transit to or from school, during school hours, and at the school-sponsored activities.

6. The district will assume no responsibility or liabilities for the administration of the medication should a student medicate him/herself at school or at school-sponsored activities.

SELF-ADMINISTRATION OF ASTHMA MEDICATION

Students with asthma are allowed to self-administer their medication if the following criteria are met:

- LHCP has instructed the student in correct and responsible use of the medication.
- Student has demonstrated to LHCP or designee, and school nurse the skills necessary to use the medication and any device that is necessary to administer the medication as prescribed.
- If indicated, the LHCP will formulate a written plan (including medication) for managing asthma at school.
- A student's parent/guardian may provide backup medication to be kept at school and in a location to which student has immediate access. **Parent/guardian will notify the school nurse if backup medication is requested at school.**
- If the student is involved in school-sponsored activities and backup medication is requested, **the parent must** contact the activity advisor or coach to make arrangements.

I certify that I am the parent, legal guardian, or other person in legal control of the student named on the reverse and I have read this form. I believe it is in the student's best interest to self-medicate and I authorize him/her to self-administer, in accordance with the instructions indicated, and the medication identified on this form by the LHCP.

Parent/Guardian Signature: _____ Date: _____

Telephone Number: _____ / _____ / _____

home work cell

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The student has demonstrated to the school nurse the skills necessary to use the asthma medication and any device that is necessary to administer the medication as prescribed.

_____ _____

School Nurse Date