HOPKINTON PUBLIC SCHOOLS

Self Administration Form for Students

Dear Parent/Guardian:

Consistent with school policy, students may self administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 210.000, “self administration” shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

Parents must complete the self administration form. The self administration agreement will be completed in the health office with your child. Your child must be able to answer the questions in the agreement or he/she will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be completed **IN ADDITION** to the parent and prescriber’s normal authorization form for administration of medication in school.

To be completed by the parent/guardian:

I request that my child _____be permitted to carry on his/her person the:

- Inhaler _____
- Epinephrine auto injector _____
- Insulin_____
- Enzyme Supplements _____

My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the steps outlined in the Self Administration Agreement.

_____ _____

(Parent/Guardian Signature) (Date)

Self Administration Agreement

School Nurse will develop a self administration plan. The student follows a procedure for documentation of self-administration of prescription medication as determined by the School Nurse. With parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication. The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the agreement.

To be completed by the school nurse with student:

Yes No

_____ _____ Student is consistently able to:

- Name the medication; Identify the correct medication;
- Explain the purpose of the medication;
- Knows the correct dosage;
- Explains when and how often the medication is to be taken;
- Describes what will happen if the medication is not taken;
- Knows where the medication will be safely stored

_____ _____ Student demonstrated the correct use/administration.

_____ _____ Student realizes his/her responsibility in carrying his/her own medication

_____ _____ Student knows not to share the medication(s) with others.

_____ _____ The student agrees to notify the school nurse or closest adult immediately after self-administering his/her medication on school-sponsored trips.

_____ _____ The student agrees to contact the nurse immediately upon taking the prescribed medication or with any questions, concerns or adverse side effects.

_____ _____ _____ _____

(Student Signature) Date (School Nurse Signature) Date