Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

Self Administration Medication Authorization Form

Dear Parent/Guardian,

District/school policy allows students to self-administer medication with school nurse and parent/guardian approval. In order for your child to carry and self administer their own medication(s), you must complete PART A of this form. PART B will be completed in the health office with your child. Your child must be able to answer the questions in Part B or they will not be permitted to self administer medication(s).

A . To Be Completed by Parent/Guardian:

I hereby request that my child be permitted to carry on their person and self-administer the medication listed within this document.

Student Name:	Medication:

My child has been instructed in and understands the purpose, appropriate method, frequency and use of their medication(s). My child understands they are responsible and accountable for carrying and administering their medication(s).

I will be responsible to ensure my child has their appropriate medication(s) on hand and support my child in following the agreement in Part B.

Parent Signature:	Date:

B. To Be Completed by the School Nurse:

Student is consistently able to **Name** the medication: **Identify** the correct medication; **Explain** the purpose of the medication; **Knows** the correct dose; **Explains** when medication is to be taken.	YES NO
Student verbally demonstrates the correct use/administration	YES NO
Student realizes their responsibility in carrying their own medication(s) in properly labeled pharmacy or manufacturer containers and agree not to share the medication with others.	YES NO
Student agrees to notify the closest adult immediately after self administering medication if experiencing any difficulties on school property.	YES NO
Student understands that the privilege of carrying and administering their own medication will be rescinded if they do not follow the above agreement.	YES NO
Student will follow a procedure for documentation of self-administration of prescription medication per the school nurse.	YES NO
"I have read and understand the above and agree to comply with these terms." Signature of Student:	Date:

Approved: YES NO	Signature of School Nurse:	Date:

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