SELF CARRY/SELF ADMINISTRATION OF NON-ASTHMA RELATED MEDICATION

Self carry and administration of medications may be authorized by the parent and medical provider and be approved by the school nurse. This includes any medications that the student may carry except asthma rescue medications.

Student Name_____ Date of Birth_____

Grade_____School Year _____

Medication Name_____Dose_____

Route_____ Time/Frequency _____

If PRN, for what symptoms_____

Relevant Side Effects_____

Discontinue Date (if applicable)_____

Prescriber's Name and Title_____

Prescriber Authorization for Self Carry/Administer (Signature)_____

Prescriber Address_____

_____

Prescriber Phone_____Prescriber Fax _____

Parent Name_____

Parent Authorization for Self Carry/Administer(Signature) _____

Date_____Parent Phone_____

To be completed by the school nurse.

_____ has demonstrated competence to administer the above medications as prescribed and within safe guidelines. The student understands and voices the potential side effects, when to notify the school nurse or representative and agrees to keep an administration record that will be delivered to the nurse weekly.

Student Signature_____Date_____

Nurse Signature_____ Date_____

Cherokee Community School District