WASECA PUBLIC SCHOOLS

SELF ADMINISTRATION OF MEDICATION
PARENT & STUDENT AGREEMENT

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and whenever leaving bldg.
- Notify health office personnel if the following occurs:
  - My symptoms reoccur within 2-3 hours after taking the medication
  - I suspect that I am experiencing side effects from my medication
  - My symptoms continue or get worse after taking the medication
  - Other_____

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

_____ _____
Signature of Student Date

I have read the above student agreement and give my permission for my child/guardian to self-administer their medication following the above procedures. I am confident that my child/guardian is knowledgeable about the medication and how to administer it safely. This agreement is in effect throughout the current school year and will need to be renewed each school year.

_____ _____
Signature of Parent/Guardian Date

The student has demonstrated knowledge about the proper use of his/her medication.

_____ _____
Signature of Licensed School Nurse Date

Medication Authorization Form with physician signature required for all prescription meds except inhalers. Physician must give his authorization for student self administration of all prescription medications with the exception of inhalers.