Paradise Valley Unified School District No. 69

**AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF MEDICATION AT SCHOOL**

(For auto-injectable epinephrine or inhaled asthma medication or insulin only)

**Student Name:** _____ **Date of Birth:** _____ **Grade:** _____

**School:** _____ **School Year:** _____

When a health care provider, parent/guardian, student and school nurse agree that self-administration of auto-injectable epinephrine or inhaled asthma medication or insulin is appropriate for an individual student, the procedure must be done safely, carefully and accurately.

The following must be completed by the prescribing health care provider, parent/guardian, student and school nurse. Orders must be renewed annually or whenever medication, dosage, or administration changes. A copy of this form shall be kept with the medication carried by the student at all times.

**PHYSICIAN'S ORDER FOR MEDICATION**

**(To Be Completed By Prescribing Health Care Provider)**

Medication name: _____ Dose: _____ Method of administration: _____

Reason for medication: _____

Time of administration: _____ ☐ For episodic/emergency events only

**Start:** ☐ Immediate ☐ Other Date: _____

**Stop:** ☐ End of Year ☐ Other Date/Duration: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (Describe): _____

Special storage requirements: ☐ Refrigerate ☐ None

Student is both capable and responsible for carrying and self-administering the above medication: ☐ Yes ☐ No

Additional comments: _____

_____

**Type or Print Physician Name and Licensed Title** | **Physician Signature** | **Date**

**Telephone Number** | **FAX Number**

**PARENT/GUARDIAN CONSENT FOR CHILD TO CARRY AND SELF-ADMINISTER MEDICATION**

**(To Be Completed by Parent/Guardian)**

I hereby give my permission for my child to carry and self-administer the prescribed medication indicated above (1) while at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as before-school or after-school care on school operated property.

It is understood and agreed if the student demonstrates irresponsibility in carrying the medication, permission to carry may be withdrawn by the school nurse. Medication must not be distributed to another student at any time. Parent/guardian assumes all liability and related loss for misuse of this medication. It is further understood that if my child violates this policy he/she will be subject to disciplinary action.

I acknowledge that I have an obligation to notify the school nurse if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

The undersigned parent/guardian, on behalf of myself, my child, our heirs, executors and assigns, hereby agrees to indemnify and hold harmless the school district, its officers, employees and agents, for any and all claims, demands, causes of action, liability or loss of any sort, because of, or arising out of, acts or omissions with respect to my child's self-administration of medication.

**PRINT Parent/Guardian Name** | **Parent/Guardian Signature** | **Date**

**Work Phone Number or Other Daytime Phone Number** | **Cell Phone Number or Pager Number**

**STUDENT AGREEMENT**

**(To Be Completed By Student)**

I agree to:

- ☐ Use correct technique for administering medication.
- ☐ Not allow anyone else to use my medication.
- ☐ Maintain a written record of my medication administration at school (e.g., in my planner, notebook, etc.).
- ☐ Keep a current supply of my medication located in (e.g., purse, backpack, etc.). _____
- ☐ Follow my health care provider's orders.
- ☐ Notify the school nurse or, in the absence of the nurse, the substitute nurse, health office back-up, a teacher or other responsible adult, under the following circumstances:
  1. My symptoms don't go away or get worse after taking my medication.
  2. I suspect that I am having side effects from my medication.
  3. Other: _____
- ☐ Notify the school nurse or, in the absence of the nurse, the substitute nurse or health office back-up, as soon as possible following use of emergency medication.
- ☐ Refill my prescriptions before they run out (or remind my parent/guardian to do so).

**Student Signature** | **Date**

Paradise Valley Unified School District No. 69

**STUDENT SELF-MEDICATION ASSESSMENT**

(To Be Completed By Professional School Nurse)

**Student Name:** _____ **School:** _____ **School Year:** _____

**AUTO-INJECTABLE EPINEPHRINE OR INHALED ASTHMA MEDICATION**

***Criteria for Self-Medication:***

| | | |
|---|---|---|
| 1. | Student is knowledgeable and capable of identifying individual medication. | ☐ Yes ☐ No |
| 2. | Student is knowledgeable of purpose of individual medication. | ☐ Yes ☐ No |
| 3. | Student is able to identify/associate specific symptom occurrence and need for medication administration. | ☐ Yes ☐ No |
| 4. | Student is knowledgeable and capable of identifying medication dosage. | ☐ Yes ☐ No |
| 5. | Student is knowledgeable about method of medication administration. | ☐ Yes ☐ No |
| 6. | Student is able to state side effects/adverse reactions to medication. | ☐ Yes ☐ No |
| 7. | Student is knowledgeable of how to access assistance for self if needed in an emergency. | ☐ Yes ☐ No |
| 8. | An Individual Health Care Plan (ICHP)/Emergency Action Plan (EAP) has been developed for the student that will monitor and evaluate the student's health status. | ☐ Yes ☐ No |

***Based on Assessment:***

| | |
|---|---|
| The student is a candidate for a self-medication program with supervision. | ☐ Yes ☐ No |
| The student has successfully completed self-medication training and has demonstrated appropriate self-administration. | ☐ Yes ☐ No |

Comments: _____

**Reviewed By:**

| | | | |
|---|---|---|---|
| **Principal Signature** | Date | **School Nurse Signature** | Date |

**DIABETIC INSULIN ADMINISTRATION**

***Criteria for Self-Management of Diabetes***

| | | |
|---|---|---|
| 1. | Student is knowledgeable and capable of blood glucose testing. | ☐ Yes ☐ No |

***Criteria for Insulin Administration (Syringe):***

| | | |
|---|---|---|
| 1. | Student is knowledgeable and capable of counting carbohydrates. | ☐ Yes ☐ No |
| 2. | Student is knowledgeable and capable of calculating amount of carbohydrates consumed. | ☐ Yes ☐ No |
| 3. | Student is knowledgeable and capable of calculating corrective dose of insulin. | ☐ Yes ☐ No |
| 4. | Student is capable of drawing up correct dosage of insulin. | ☐ Yes ☐ No |
| 5. | Student is knowledgeable about administering insulin at appropriate site. | ☐ Yes ☐ No |
| 6. | Student is knowledgeable of the proper method for disposal of equipment. | ☐ Yes ☐ No |

***Criteria for Insulin Administration (Pen):***

| | | |
|---|---|---|
| 1. | Student is knowledgeable and capable of counting carbohydrates. | ☐ Yes ☐ No |
| 2. | Student is knowledgeable and capable of calculating amount of carbohydrates consumed. | ☐ Yes ☐ No |
| 3. | Student is knowledgeable and capable of calculating corrective dose of insulin. | ☐ Yes ☐ No |
| 4. | Student is knowledgeable about administering insulin at appropriate site. | ☐ Yes ☐ No |
| 5. | Student is knowledgeable of the proper method for disposal of needles. | ☐ Yes ☐ No |

***Criteria for Insulin Administration (Pump):***

| | | |
|---|---|---|
| 1. | Student is knowledgeable and capable of counting carbohydrates. | ☐ Yes ☐ No |
| 2. | Student is able to bolus correct amount for carbohydrates consumed. | ☐ Yes ☐ No |
| 3. | Student is capable of calculating and administering corrective bolus. | ☐ Yes ☐ No |
| 4. | Student is knowledgeable and capable of calculating and setting basal profiles. | ☐ Yes ☐ No |
| 5. | Student is knowledgeable and capable of calculating and setting temporary basal rate. | ☐ Yes ☐ No |
| 6. | Student is knowledgeable and capable of disconnecting pump. | ☐ Yes ☐ No |
| 7. | Student is knowledgeable and capable of reconnecting pump at infusion set. | ☐ Yes ☐ No |
| 8. | Student is knowledgeable and capable of preparing reservoir and tubing. | ☐ Yes ☐ No |
| 9. | Student is capable of inserting infusion set. | ☐ Yes ☐ No |
| 10. | Student is able to troubleshoot alarms and malfunctions. | ☐ Yes ☐ No |

***Based on Assessment:***

| | |
|---|---|
| The student is a candidate for a self-medication program with supervision. | ☐ Yes ☐ No |
| The student has successfully completed self-medication training and has demonstrated appropriate self-administration. | ☐ Yes ☐ No |

Comments: _____

**Reviewed By:**

| | | | |
|---|---|---|---|
| **Principal Signature** | Date | **School Nurse Signature** | Date |

**NOTE:** If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider to attempt to agree upon a plan. In the event agreement is not reached, the parents may refer the case to the assigned district lead nurse for resolution. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the assigned district lead nurse.