Self-Administration of Non-Asthma Medication at School
Health Care Provider and Parent Permission Form

Date: _____

The policy of Stillwater Area Schools-District 834 regarding the dispensation of medication in school is that medication shall be administered only when the student's health requires medication during school hours.

Minnesota State Law (M.S. 126.201) requires medications which are administered at school must be in a container or prescription bottle properly labeled by a pharmacist or physician. Pharmacists should be asked to divide the medication between two containers completely labeled; one for home and one for school. District 834 policy requires a written order from a licensed prescriber and authorization from the parent/guardian for the student to self-administer medication. Please return this form to the school nurse. (See form M-4 for asthma medication.)

_____	_____	_____	_____
School Nurse	School	Phone	Fax Number

This section to be completed by Physician/Prescriber

_____ is to receive _____
(Patient's Name) (Medication and Dosage)

at _____ for the treatment of _____
(Time) (Condition)

Possible Side Effects: _____ Estimated Date of Termination: _____

I authorize the student named above to self-administer this medication at school and thereby release the school nurse or designated school personnel from liability regarding medication administration.

_____	_____	_____
Print or Type Name of Licensed Prescriber	Clinic Name	Physician's / Licensed Prescriber's Signature

_____	_____	_____
Clinic Phone Number	Clinic Fax Number	Date

Parent/Guardian Authorization

1. I/we request our child to be able to carry and take their own medication and/or syringe at school as prescribed above. I/we release the school personnel from liability in the event adverse reactions result from taking the medication(s) by our child outside of the health room. I/we will also provide a supplement bottle of medication for the health room to store in case of loss of the medication at school.
2. I/we will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.) My/our child will sign and follow the agreement with the Licensed School Nurse on the back of this form.
3. I/we give permission for the school nurse to consult with the above named student's licensed prescriber regarding any questions that arise with the listed medication(s) or medical condition(s) being treated.

☐ My child may self-administer their medication as needed.

_____	_____	_____	_____
Parent/Guardian Signature	Relationship to Student	Date	Daytime phone number

Minnesota Statutes 121A.22: Medication must be supplied in the original prescription bottle or container/syringe with student's name on it.

Self-Administration of Medication Other Than for Asthma or Pain Relief

(See forms M-4 for asthma and M-5 for non-prescription pain relief self-administration)

Student Agreement

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration technique.
3. Maintain a written record of my medication administration at school.
4. Not allow anyone else to use my medication.
5. Keep a supply of my medication with me in school and on field trips.
6. Notify the school health office personnel if any of the following occurs:
    - My symptoms continue or get worse after taking the medication.
    - My symptoms reoccur within 2-3 hours after taking the medication
    - I suspect that I am experiencing side effects from my medication
    - Other _____
7. 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**

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

_____ _____

Signature of Licensed School Nurse or RN **Date**